Livingston Dental

800 South Washington
Afton , WY 83110
307-885-4337

124 Petersen Parkway Suite #3
Thayne, WY 83127
307-883-4337

1 About You

Today's Date:____/___/_____

Patient Name: ________________________________

What you Prefer to Be Called:__________ ☐Male ☐Female

Birth date:____/___/____ Age:____ SS#: ______________

Mailing Address:

____

____

Driver's License #: __________________________State:____

Home Phone#:(_____) __________________________

Work Phone#:(_____)__________________________

Cell Phone#: (_____) __________________________

E-mail Address:________________________________

Referred By:________________________________

Employer:__________________ How Long?__________

Employer's Address:_____________________________

____

Occupation:________________________________

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____________________________

Do you have children? ☐Yes ☐No How Many?__________

Do You Have Dental Insurance? ☐Yes ☐No (If Yes Please provide front office personnel with card so they can photocopy it.)

Insurance Agreement: I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me. And that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated potion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

______________________________ __________

Signature of responsible party **Date**

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2 Account Information

Person Ultimately Responsible for Account

Name:________________________________

Relation:________________________________

Billing Address: ___________________________

____

SS#:______-_______-______ DOB: _____/____/_______

Work Phone#:(____)__________________

Payment Method: ☐ Cash ☐ Check

☐**Credit Card (please put card info below)**

Card # ______________________________

___/___ exp 3 digit code from back ____

☐**Care Credit** (Please put card info below)

Card#______________________________

PLEASE INITIAL

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

_____I hereby authorize that any unpaid balance that my insurance benefits did not pay to be charged to the credit card, or Care Credit # listed above.

3 In Event of Emergency

Whom should we contact?_____________________

Relation_____________________________

Phone (____)__________ Cell (____)____________

Who is your Medical Doctor?____________________

Medical Doctor's Phone #:(____)________________

4 Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are You in pain? ☐ No ☐ Yes How Long?________________

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth

☐ Red, swollen or bleeding gums. ☐ Teeth Grinding ☐ Locking Jaw

☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad Breath

☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth/teeth

☐ Other:________________________________

Do you require pre-medication? ☐ Yes ☐ No ☐ I don't know

Previous Dentist:____________________ Phone (____)__________

Last Dental Exam:____/____/____ Last Dental Xray: ____/____/____

Times a day you brush?__________ Times a week you floss?__________

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

5 Medical History

What medications are you taking? ☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis. Others:________________________________

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Alcohol/Drug Abuse	**Y N** Chest Pains	**Y N** Heart Attack/Stroke	**Y N** Liver Problems	**Y N** Sleep Apnea
Y N Anemia	**Y N** Congenital Heart Defect	**Y N** Heart Disease	**Y N** Mitral Valve Prolapse	**Y N** Snoring
Y N Arthritis/Rheumatism	**Y N** Cosmetic Surgery	**Y N** Heart Murmur	**Y N** Nervousness	**Y N** Stomach Problems
Y N Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia	**Y N** Heart Surgery/Pacemaker	**Y N** Psychiatric Problems	**Y N** Thyroid Problems
Y N Artificial Valves	**Y N** Difficulty Breathing/COPD	**Y N** Hepatitis A/B/C	**Y N** Respiratory Problems	**Y N** Tuberculosis TB
Y N Asthma	**Y N** Dry Mouth/Cold Sores	**Y N** Blood Pressure– High/Low	**Y N** Rheumatic Fever	**Y N** Venereal Disease
Y N Back Problems	**Y N** Emphysema	**Y N** HIV+/AIDS/ARC	**Y N** Scarlet Fever	**Y N** X-Ray/Cobalt Treatment
Y N Bleeding Problems	**Y N** Frequent Headaches	**Y N** Jaw Problems/TMJ/TMD	**Y N** Seizures/Epilepsy	
Y N Cancer/Tumors	**Y N** Frequent Neck Pain	**Y N** Kidney Problems	**Y N** Shingles	
Y N Chemotherapy	**Y N** Glaucoma	**Y N** Leukemia	**Y N** Sinus Problems	

Please list any other surgeries or medical conditions you have or ever have had:

____

____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Foods:____________________ ☐ Others:____________________

Do you use tobacco? ☐ Yes ☐ No (If Yes) How used?__________ How much?__________ How Long?__________

Do you use cannabis? ☐ Yes ☐ No (If Yes) How used?__________ How much?__________ How Long?__________

Please rate your general health from 1-10:__________ Are you pregnant? Y N__________

- We Invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Financial Coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. We file insurance as a courtesy to you and amounts quoted are only an estimate. Patient is responsible for entire balance regardless of insurance.
- I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that my be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ________________________________ **Date:** ____________________

Livingston Dental | **Ph#:307-885-4337**
Patient Authorization | **Fax:307-885-4334**

_____ **I authorize** the release of my dental records and x-rays from Livingston Dental and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Livingston Dental.
_____ **I authorize** insurance payments to be made directly to Livingston Dental. I understand I am responsible for any unpaid balance.
____ **I am aware** that not providing adequate notice to change a reservation, I may be charged a $50.00 fee per reservation. (7 calendar days for a surgical reservation and 2 business days for a cleaning reservation exam.)
____ **I am aware** of and received notice of the Health Insurance Portability and Accountability Act (HIPPA)

Notice of Privacy Practice-Acknowledgment

We keep records of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct the record. We will not dis close you record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your records or get more information about it by contacting us.
Our **Notice of privacy Practices** describes in more detail hoe your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.
As a courtesy to our new patients, we often will give a variety of reservation reminders. Some of these Reminders may generally include, but are not limited to, reservation post-cards sent through the mail. Messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's reservation time and date, or need for a reservation may be included. To respond to the text message, simply type YES and send. We receive the response and will mark you as confirmed.

AS my signature below, I authorize Livingston Dental and staff to confirm my reservation and remind me of the need for a reservation in the above-mentioned ways, for the duration of my treatment with their office.

Authorize to Discuss Treatment & Financial Information

By my signature below, I authorize Livingston Dental and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.
Name:________________________ **Relationship to Patient:**________________ **Cell Phone:** __________________
Name:________________________ **Relationship to Patient:**________________ **Cell Phone:** __________________

- I do not authorize Livingston Dental to discuss treatment and financial information with anyone other than myself.

Patient's Signature:____ **Date:**_________________

Financial Agreement

This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, please bring proof of insurance at each appointment. Keep track of all your insurance statements and correspondence in order to ensure you are getting the maximum insurance benefits.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Outside financing is available through CareCredit upon request and approval.

Returned checks will be charged $35.00. Balances older than 60 days will be subject to collection fees and finance charges at the rate 1.5% per month (18% annually).

Additionally, our office reserves the option to charge you for appointments that you do not keep and for appointments that you do not cancel with 48 hour notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

_________________________________ ___________________________

Print Name of Patient or Responsible Party Date

____

Signature

Adult Sleep & Breathing Questionnaire

Date: ______________________

Patient 's Name: ______________________________

Patient's Date of Birth: ____________________ Age: ________

Male ______ Female ______

Have you ever had a sleep test administered? ______yes ______no

If yes - when did you have your last sleep test? ______________________

Have you been diagnosed with Sleep Apnea? ______yes ______no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? ______yes ______no

Are you happy with your CPAP or Sleep Appliance? ______yes ______no

If you are not happy - why? ______________________________

____

____

How often do you get out of bed to use the restroom during the night? ____________

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐