

Media & Social Release Form

As a part of a vibrant company, we like to promote patient and office activities and celebrate achievements from time to time on social media and other outlets. For example, we might make a social media post like:

"Congratulations to our No Cavity Club member, (Patient Name) for completing yet another cavity free hygiene appointment! You are on your way to getting a big prize and a lifetime of good dental health!" (This post may include a picture with the patient and their hygienist)

I, _____ (please print), do hereby consent and agree that Divine Expressions Family Dentistry, its employees, or agents have the right to take photographs, videotape, or digital recordings of me and to use these in any and all media, now or hereafter known, and exclusively for the purpose of advertising, education and other promotions. I further consent that my name and identity may be revealed therein or by descriptive text or commentary. I do hereby release to Divine Expressions Family Dentistry its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. All negatives, prints, digital reproductions shall be property of Divine Expressions Family Dentistry. I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Divine Expressions Family Dentistry is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result. I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

We do acknowledge that any patients that are under 18 years of age may not sign this without their parent present or their parents' permission. If you are a parent signing for your child, please enter their name in the spaces provided below.

The Health Insurance Portability and Accountability Act still holds its place and I have been informed that absolutely no medical information will be release with the signing of this form.

☐ I refuse to release Divine Expressions Family Dentistry the right to take photographs, videotape, or take digital recordings of me and to use in any and all media outlets.

Name: _____

Signature: _____ Date _____

DIVINE EXPRESSIONS FAMILY DENTISTRY



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement*****

I have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ *Individual refused to sign*
- ☐ *Communication barriers prohibited obtaining the acknowledgement*
- ☐ *An emergency situation prevented us from obtaining acknowledgement*
- ☐ *Other (Please Specify)*

HIPAA PRIVACY NOTICE

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- ♦ Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- ♦ Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- ♦ Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Patient Name: _____ Date: _____
 First *Middle* *Last*

EPSS 00

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

Scoring

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Situation		*Pre- / With OAT / OAT
1.	Sitting and reading	___ / ___
2.	Watching TV	___ / ___
3.	Sitting inactive in a public place (i.e. a theater or a meeting)	___ / ___
4.	As a passenger in a car for an hour without a break	___ / ___
5.	Lying down to rest in the afternoon when circumstances permit	___ / ___
6.	Sitting and talking to someone	___ / ___
7.	Sitting quietly after lunch without alcohol	___ / ___
8.	In a car, while stopped for a few minutes in traffic	___ / ___
Total Score:		___ / ___

*Pre-OAT areas do not change

Key Reference

Johns, M. (1991). A New Method for Measuring Daytime Sleepiness: The Epworth Sleepiness Scale. *Sleep*, 540 - 545.

MEDICATIONS AND CONDITIONS

Please list all medications/treatments you are currently taking and the reason you take them. (Include all over-the-counter medications, vitamins, herbs, etc.)

Medication	Dosage	Reason for Taking

Treatment	Doctor/Provider Name	Approximate Date of Treatment

Pharmacy Name: _____

Pharmacy Phone Number: _____

CURRENT SLEEP DISORDERED BREATHING TREATMENT

Have you been prescribed the C-PAP to manage your sleep-related breathing disorder (apnea)? ☐ Yes ☐ No

If you have not been prescribed a C-PAP, please move ahead to the **RELEASE OF FINDINGS** section.

If yes, do you wear your C-PAP as prescribed? ☐ Yes ☐ No

If you do not wear your C-PAP as prescribed, check the reason(s) below:

- | | |
|--|--|
| <input type="checkbox"/> Mask leaks | <input type="checkbox"/> Straps/headgear cause discomfort |
| <input type="checkbox"/> Mask/device is uncomfortable | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Unable to sleep comfortably | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Noise disturbs sleep and/or bed partner's sleep | <input type="checkbox"/> Does not seem to be effective |
| <input type="checkbox"/> Movement is restricted during sleep | <input type="checkbox"/> Pressure on the upper lip causes tooth related problems |
| <input type="checkbox"/> Other | |

RELEASE OF FINDINGS

I authorize the release of all examination findings and diagnosis, reports and treatment plans, to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction.

- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Metals

- ☐ Codeine
- ☐ Iodine
- ☐ Barbituates
- ☐ Sedatives

- ☐ Penicillin
- ☐ Plastic
- ☐ Latex
- ☐ Sulfa

Other: _____

HEALTH AND MEDICAL HISTORY (Social)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you currently pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke tobacco? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Had prior orthodontic treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you drink 4 or more cups of coffee per day? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you sustained injury to: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you consume alcohol and/or sedatives? |
| | <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Teeth | | |

Do you have, or have you experienced any of the following?

- | | | | |
|--|-------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anxiety |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary tract disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic fatigue syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen, stiff or painful joints |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruising easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty concentrating | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent weight gain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty breathing while sleeping | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Insomnia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastroesophageal reflux (GERD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent morning sore throat |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent night waking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Memory loss |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary Artery Disease (CAD) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty concentrating | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Heart Failure (CHF) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Arterial Hypertension | | |

Additional condition(s): _____

Mouth and Nose Related Conditions

- | | | | |
|--|--------------------------------|--|------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic sinusitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent snoring | <input type="checkbox"/> Yes <input type="checkbox"/> No | Burning tongue |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Broken tooth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent biting of the cheek |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Trouble breathing through nose | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw locking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Teeth grinding (Bruxism) |

Sleep Conditions

Please select answers based on your average sleep experience and/or what a sleep partner has told you.

- | | | | |
|--|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is it easy to fall asleep? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had a sleep study? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you feel rested upon AM waking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you wake often during the night? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stopped breathing during sleep? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gasping or choking during sleep? |
- Sleep Positions: ☐ Side ☐ Back ☐ Stomach ☐ Varies Average hours of sleep per night? _____

SURGICAL HISTORY

Have you had any of the following?

- | | | | |
|--|--------------------|--|---------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | General anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthognathic surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Adenoids removed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Oral surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsils removed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Removal of third molar (wisdom teeth) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw joint surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other surgery |

Other types of surgery: _____

HISTORY OF SYMPTOMS (Family)

On what date, or approximate date, did the chief complaint condition or symptoms first occur? _____
Does any family member have the same or similar problem? ☐ Yes ☐ No If yes, please explain: _____

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? ☐ Yes ☐ No

Patient Health Questionnaire

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____
 First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Number: _____

Occupation: _____ Company: _____

Dentist: _____ Phone: _____

Physician: _____ Phone: _____

CHIEF COMPLAINT

Circle the chief complaint and place a check mark next to all other symptoms you are experiencing.

- | | |
|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Kicking or jerking leg repeatedly |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Swelling in ankles or feet |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Morning hoarseness |
| <input type="checkbox"/> Pain when chewing | <input type="checkbox"/> Dry mouth upon waking |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Throat pain | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Tossing and turning frequently |
| <input type="checkbox"/> Limited ability to open mouth | <input type="checkbox"/> Repeated awakening |
| <input type="checkbox"/> Jaw joint locking | <input type="checkbox"/> Feeling unrefreshed in the morning |
| <input type="checkbox"/> Jaw joint noises | <input type="checkbox"/> Significant daytime drowsiness |
| <input type="checkbox"/> Ear congestion | <input type="checkbox"/> Frequent heavy snoring affects sleep of others |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Gasping when waking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Told that I stop breathing during sleep |
| <input type="checkbox"/> Tinnitus (ringing in the ears) | <input type="checkbox"/> Night-time choking spells |
| <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> Unable to tolerate C-PAP |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Teeth crowding |
| <input type="checkbox"/> Teeth grinding | |
| Other: _____ | |

Do you have concerns in any of these areas:

☐ Appearance

☐ Bite

☐ None

☐ Ability to chew

☐ Smile

☐ Snoring

Other comments: _____

Do any of the above complaints or concerns affect your daily life? _____

What kind of results are you hoping to achieve from treatment? _____

DIVINE EXPRESSIONS FAMILY DENTISTRY



DENTAL SURVEY

Tell Us About Your Smile

Please take a moment to tell us about your smile so that we may better serve your individual needs.

When I see a picture of myself, the first thing I notice about my smile is:

Some things that I consider attractive in other people's smiles are:

*****Please "✓" the statements below that apply to you.***

- ◇ I wish my teeth were straighter.
- ◇ I wish I had a broader smile.
- ◇ I think some of my teeth are too small.
- ◇ I think some of my teeth are too large.
- ◇ I wish my teeth were whiter with regard to their color.
- ◇ I think my gums show too much when I smile.
- ◇ I think my smile shows too much space between some of my teeth.
- ◇ Because I am not totally pleased with my teeth, I sometimes hesitate to smile.
- ◇ I feel as though I don't really know all of the options available to me for enhancing my smile.
- ◇ Concerns over what the end result might look like have been a factor in my not having aesthetic dentistry in my mouth.
- ◇ Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
- ◇ I feel as though I could do a better job of protecting the health of my teeth and gums, and therefore, the longevity of my smile.

Welcome

Thank you for selecting Divine Expressions Family Dentistry! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely (in ink, please print). If you have any questions or need assistance, please ask us - we will be glad to help.



PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address 2: _____
 City, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
 City: _____ State / Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
 Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____
 E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired
 Student Status: ☐ Full Time ☐ Part Time
 Medicaid ID: _____ Pref. Dentist: _____
 Employer ID: _____ Pref. Pharmacy: _____
 Carrier ID: _____ Pref. Hyg.: _____

Section 3

Emerg. contact: _____
 Emerg. number: _____
 Pre-medicate? Yes/No: _____
 Referred by whom?: _____
 Your Employer?: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

**Divine Expressions Family Dentistry
Dr. Laurentis L. Barnett
7185 Highway 72 West, Suite C
Madison, AL 35758
256-837-1200**

Thank you for choosing Divine Expressions Family Dentistry! Our goal here at Divine Expressions is to provide our patients with the quality of dentistry that we require ourselves. We believe that communication is paramount to a healthy doctor/patient relationship. Please carefully read and initial acknowledging the practice policies. We look forward to taking care of all your dental needs!

- I understand that co-pays and payments are due prior to the beginning of all treatment.
- I understand that return checks will be accessed a fee of \$30.00.
- I understand that in the event of non-payment, or default, the patient/guardian will be responsible for all costs of collection, in addition to the outstanding balance.
- I understand and agree to give a 24-hour cancelation notice for any appointment made otherwise I will be charged \$55.00.
- I understand that if I am unable to make my reserved appointment time within a 15-minute window Divine Expressions reserves the right to rescheduled my appointment.
- I understand that if I require a prescription for valium or lorazepam for dental anxiety I am required to bring a driver, otherwise my appointment will be rescheduled.
- I understand that I cannot drop my minor child, under 14, off for dental treatment nor can I leave once the procedure starts. Any child over 14 is able to give consent for treatment.
- I understand that I must also give a verbal confirmation or leave a message on the voicemail otherwise, my appointment will be rescheduled.
- I understand that cell phone usage is not permitted in the treatment area.
- I understand that if my insurance provider has not paid after 60 days of my treatment the balance is due by me.

By signing I agree that I have read and understand the office policies of Divine Expressions Family Dentistry to ensure I receive the best possible care.

Signature

Date