Premier Dental Care
220 Horizon Dr., Suite F
Henderson, NV 89015

Alex Y. Song, D.D.S.

CHART #______________

Personal Information

Patient Name Last ____________________ First __________________ Initial ____ Birthdate __________

Soc. Sec. # ______________________________ Male_________ Female ________________

Marital Status: Married_________ Single_________ Child__________

Address ____ Apt. ____________

City ________________________________ State_______________ Zip Code___________

Home Telephone # (_____)_________________ Cell Phone #(_____)____________________

E-Mail Address ____

Preferred Contact Number (circle one): Home / Cell / Work

Employer ___________________________________ Position _______________________

Employer Address _________________________ City _______________ Zip ___________

Employer Telephone # (_____)_______________ Fax #_(_____)_____________________

Parent/Spouse Name Last _____________________ First ____________________ Initial _______

Medical Physician of Above Patient ____

Telephone # (_____)__________________ Fax #(_____)__________________________

Previous Dentist _______________________________ Telephone # (_____)____________

Name & Address

** Emergency Contact **

Name_________________________ Relationship ____________ Phone # (____)__________

CHART#__________________

Dental History and Information

Are your teeth sensitive to heat or cold, pressure, or sweets? O *Yes* O *NO* Specify :
Do your gums bleed when you brush? O *Yes* O *NO*
Do you clench or grind your teeth? O *Yes* O *NO*
Are you having pain or discomfort at this time? O *Yes* O *NO* Date of last exam______

Medical History and Information

Are you under a physician's care now? O *Yes* O *NO* Reason .
____
Have you been hospitalized in the past two years? O *Yes* O *NO* Reason________________
Are you taking any drugs or medications? O *Yes* O *NO* Reason ________________
Do you have artificial joints/pins ? O *Yes* O *NO* Where? ________________

If female please answer the following:

Y	N	
O	O	Are you taking Birth Control Pills?
O	O	Are you pregnant? # of weeks? ☐
O	O	Are you nursing?

Please answer the following:

Y	*N*	
O	*O*	Do you smoke or use tobacco?

FOR OFFICE USE ONLY

BP __________ Heart Rate__________

Please CIRCLE Y (yes) or N (no) to all of the following:

Conditions	**Conditions**	**Conditions**
Y N Abnormal Bleeding	Y N Glaucoma	Y N Sinus Problems
Y N Alcohol Abuse	Y N Hay Fever	Y N Stroke
Y N Allergies	Y N Heart Attack	Y N Thyroid Problems
Y N Anemia	Y N Heart Surgery	Y N Tuberculosis
Y N Angina Pectoris	Y N Hemophilia	Y N Ulcers
Y N Arthritis	Y N Hepatitis A	Y N Venereal Disease
Y N Artificial Bones	Y N Hepatitis B	Y N Yellow Jaundice
Y N Artificial Heart Valve	Y N Hepatitis C	Y N Heart Murmur
Y N Asthma	Y N High Blood Pressure	**Allergies**
Y N Blood Transfusion	Y N HIV + AIDS	Y N Aspirin
Y N Cancer -Chemotherapy	Y N Kidney Problems	Y N Codeine
Y N Colitis	Y N Liver Disease	Y N Dental Anesthetics
Y N Congenital Heart Defect	Y N Low Blood Disease	Y N Erythromycin
Y N Cosmetic Surgery	Y N Mitral Valve Prolapse	Y N Jewelry
Y N Diabetes	Y N Pace Maker	Y N Latex
Y N Difficulty Breathing	Y N Pneumocystitis	Y N Metals
Y N Drug abuse	Y N Psychiatric Problems	Y N Penicillin
Y N Emphysema	Y N Radiation Therapy	Y N Tetracycline
Y N Epilepsy	Y N Rheumatic Fever	Other: ________________
Y N Fainting Spells	Y N Seizures	________________
Y N Fever Blisters	Y N Shingles	________________
Y N Frequent Headaches	Y N Sickle Cell Disease	

Do you have or have you had any disease, condition or problem not listed above? O Yes or O No
Explain ____
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I will inform the dentist and staff before the next appointment.
X ________________________________ Date ________________________
Patient or responsible party signature

FOR OFFICE USE: Reviewed by ____________________ Date ____________________

MEDICAL UPDATES

I have read my medical history dated ________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY

SLEEP GROUP SOLUTIONS

Initial Patient Sleep Screening Form

Patient Name (PRINT) ____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading..	0	1	2	3 Watching
television... 0	1	2	3	
Sitting in a public place..	0	1	2	3
As a passenger in a car for one hour....................................	0	1	2	3
Driving a car stopped for a few minutes in traffic.......................	0	1	2	3
Sitting & talking to someone..	0	1	2	3
Sitting down quietly after lunch without alcohol.......................	0	1	2	3
Lying down to rest in the afternoon..	0	1	2	3

Total Score: ______

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

			No (0)	Yes (1)
BMI (See Attached Chart):	______	Is it greater than or equal to 30?	0	1
Neck Circumference	______	Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15 pounds in the past 6 months?			0	1

Total Score: ______

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question

	No (0)	Yes (1)
Do you snore?..	0	1
You, or your spouse, would consider your snoring louder than a person talking....	0	1
Your snoring occurs almost every night..	0	1
Your snoring is bothersome to your bed partner....................................	0	1
Do you feel that in some way your sleep is not refreshing or restful?....................	0	1
Do you wake up at night or in the mornings with headaches?...............................	0	1
Do you experience fatigue during the day and have difficulty staying awake?.......	0	1
Do you have trouble remembering things or paying attention during the day?.......	0	1
Do you have high blood pressure?..	0	1

Total Score: ______

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:

When were you diagnosed? (Approx mo/yr) ____________

Were you put on CPAP Therapy for treatment? ____________

Are you still using your CPAP every night? ____________

Total Score: ______

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

Patient Signature: ______________________________ **Date:** ____/____/________

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.

_____ ESS Score ≥ 8? _____ Pt. Eval ≥ 2? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1?

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CHART # ____________

Primary Insurance Information

Name of Insured Last ____________________ First ____________________ Initial ______

Soc. Sec. #____________ D.O.B ________ Relationship to patient____________

Address (if different from patient's) ____________________ Phone (__)__________

City ____________________________ State ____________Zip______________

Employed by ______________________________Occupation________________

Employers Address ____________________________Work Phone#(__)__________

Insurance Company ______________________________Phone#________________

Address ____________________City _______________State______ Zip__________

Secondary Insurance Information

Name of Insured Last ____________________ First ____________________ Initial ______

Soc. Sec. #____________ D.O.B ________ Relationship to patient____________

Address (if different from patient's) ____________________ Phone (__)__________

City ____________________________ State ____________Zip______________

Employed by ______________________________Occupation________________

Employers Address ____________________________Work Phone#(__)__________

Insurance Company ______________________________Phone#________________

Address ____________________City _______________State______ Zip__________

Assignment of benefits: I hereby authorize and request my insurance company to pay directly to Premier Dental Care the amount due on my claim for services rendered to my dependant or me. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference; and if the nature of the liability were such that it is not covered by the policy, I will be responsible to Premier Dental Care for payment of the entire bill.

Signed: ________________________________ Date: __________________

LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

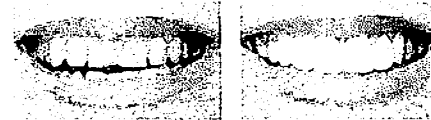
NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully then answer the following questions:

1 Do you like the appearance of your teeth and your smile? ❑ Yes ❑ No
If not, explain ______________________________

____



STAINED AND CHIPPED

2 Are your teeth all in alignment (straight)? ❑ Yes ❑ No
If not, explain ______________________________

____

3 Do you have spaces that you don't like? ❑ Yes ❑ No
If yes, explain ______________________________

____

SPACES

4 Do you like the color of your teeth? ❑ Yes ❑ No
If not, explain ______________________________

____

CALCIFICATION STAINS

5 Do you like the shape of your teeth? ❑ Yes ❑ No
If not, explain ______________________________

____

6 Are your teeth...
Chipped? ❑ Yes ❑ No Protruding ❑ Yes ❑ No Hidden ❑ Yes ❑ No
If yes, explain ______________________________

____

FANGED TEETH

7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain ______________________________

____

STAINED AND CROOKED TEETH

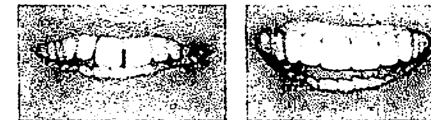
8 Are there old fillings or dental work you don't like looking at? ❑ Yes ❑ No
If yes, explain ______________________________

____

9 What would you like to change the most in the appearance of your teeth?

____

____



PORCELAIN CROWNS

10 How would you like your teeth to look?

____

____

BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.

LUMINEERS®
BY CERINATE®
lumineers.com

Cerinate Smile Design Studios, 2727 Skyway Drive, Santa Maria, CA 93455 • 877-LUMINEERS • www.lumineers.com

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Welcome to Premier Dental

CHART # ___________

How did you hear about our office?

*** Please mark all that apply***

____ Friend or patient referral: Name of referring person ________________

____ Specialist or other Dentist: Dentist name __________________________

____ Mailer /Advertisement

_____ Physical Location

_____ Insurance company referral

_____ Postcards

_____ Sprint Yellow Pages

_____ Yellow Book Yellow Pages

______ Discount Plan

______Internet

Are you happy with the appearance of your teeth? _____ Yes _____ No

Please check the boxes of all that apply:

- ❑ Do you have a toothache?
- ❑ Do you grind you teeth?
- ❑ Do your gums bleed?
- ❑ Do your jaw joints pop or click?
- ❑ Do you have pain in jaw joints?
- ❑ Do you have ringing or fullness in your ears?
- ❑ Headaches, if yes how often _____
- ❑ Loose teeth
- ❑ Broken or chipped teeth or fillings
- ❑ Bad breath
- ❑ Teeth sensitive to hot
- ❑ Teeth sensitive to cold
- ❑ Teeth sensitive to sweets
- ❑ Teeth sensitive to biting
- ❑ Teeth that trap food between them
- ❑ Have you ever been treated by an Orthodontist
- ❑ Have you ever been treated by an Periodontist

Why did you leave your last dentist?____

____

Please list your sports activities and hobbies ______________________________________

PERMISSION TO UTILIZE PATIENT'S RECORDS

I hereby grant Dr. Alex Y. Song and associates permission to use the diagnostic and treatment photographs, models, and records of:

____

(Patient's name)

For the purpose of display for office, website, scientific articles, seminars, presentation, etc.

Patient or parent's signature ______________________________ Date ___________

HIPPA Notice of Privacy Practices

Name: ____ Chart#: ___________

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your (PHI) information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by a physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your name, photograph, and email address in order to obtain a LumiSmile picture. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Laws Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of health and human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Chart#: ________

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on / or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our (702) 563-6956.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ______________________ **Signature:** ______________________ **Date:** __________

Please provide the following information if you would like to authorize our office to release your information: (optional)

I, ______________________________, authorize the release of treatment and financial

records pertaining to ______________________________(patient name) to the

following people:

______________________________Relationship______________

______________________________Relationship______________

______________________________Relationship______________