RICHARDS FRANKEL DENTISTRY

Dentistry designed for health and well being.

Dear ________________________, I would like to thank you and welcome you to our office. I'll start by sharing with you what our guiding beliefs are for our patients.

Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them, recognizing that not all patients have the same dental needs or desires.

With that in mind we would ask you to identify how you would like to be seen in her office by checking which of the 3 levels seem appropriate for you at this time. Please understand that it is not uncommon for patients to choose a different path after they have experienced our office, but this helps as a starting point.

- ☐ Level 1: Reactive care, patients at this level are generally only interested in solving more urgent problems and not in a comprehensive exam or long-term planning. In addition, they typically want the treatment performed to be as inexpensive and efficient as possible.
- ☐ Level 2: Proactive care, patients who choose this level of care generally want a thorough examination and want to be involved in the prevention of present and future dental problems. Typically, however they choose repair solutions that are not long-term in nature.
- ☐ Level 3: regenerative care, patients at this level have a high value for their dental health and appearance. They desire a complete dental examination and have a desire to be informed of all findings in the potential consequences of each problem. Ultimately, they want to be involved in creating a long-term master plan for their dental health which includes choosing the longest lasting solutions to their problems.

We hope these different levels make sense to you, and as we stated before, it is not uncommon for patients to change levels after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care most appropriate for you.

We thank you for choosing Richards Frankel Dentistry as your dental home,

Richards Frankel Dentistry Team

Dr. Margaret Frankel

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PATIENT INFORMATION

1. Date ____
2. Full Name Mr., Ms., Mrs., Miss, Dr. _________________________
   ____
3. Date of Birth ____________________________________
4. Social Security Number ____________________________
5. HIC/Patient ID Number _____________________________
6. Marital Status (Please circle) Single // Married // Divorced // Widowed
7. Address ____
   - City ____________________________________
   - State ___________________________________
   - Zip _____________________________________
8. Home Phone ______________________________________
9. Cell Phone _______________________________________
10. Email Address ____________________________________
11. Employed by ______________________________________
12. Occupation _______________________________________
13. Business Address __________________________________
    - City ____________________________________
    - State ___________________________________
    - Zip _____________________________________
14. Business Phone ____________________________________
15. Do you have dental insurance coverage _______________ Ⓨ Ⓝ
    - Name of insured ____________________________
    - Date of birth ______________________________
    - Social security number ______________________
    - Name of carrier ____________________________
    - Member ID _________________________________
    - Group number ______________________________
    - Address ___________________________________
    - Phone number ______________________________
16. Previous Family Dentist's Name __________________________
17. Physician's Name ____________________________________
18. Physician's Phone Number: _____________________________
19. How did you hear about us? ____________________________
    ____

PATIENT HEALTH HISTORY

Please answer the following accurately and completely. The diagnosis and treatment of your condition depends on the identification of every possible contributing factor. Although some of the questions may seem unrelated to your dental condition, they are all associated with proper management of your oral health.

20. Are you in good health ______________________________ Ⓨ Ⓝ
21. Has there recently been any changes to your health _______ Ⓨ Ⓝ
22. Have you gained or lost weight in recent months _________ Ⓨ Ⓝ
    - If so, how much ________________________________
23. Have you had any serious illnesses or operations ________ Ⓨ Ⓝ
    - If so, please explain ____________________________
      ____
24. Are you currently under the care of a physician ___________ Ⓨ Ⓝ
    - If so, for what ________________________________
25. Date of last physical exam ______________________________
    ____
26. Physician's name ____________________________________
27. Are you presently taking any drugs or medications _______ Ⓨ Ⓝ
    - If so, please list ______________________________
      ____
28. Are you taking or have you ever taken bisphosphonate medications
    ____ Ⓨ Ⓝ
29. Do you currently have or previously had any of the following conditions
    - Heart Disease _____________________________ Ⓨ Ⓝ
    - Rheumatic Fever ___________________________ Ⓨ Ⓝ
    - High Blood Pressure ________________________ Ⓨ Ⓝ
    - Stroke ___________________________________ Ⓨ Ⓝ
    - Congenital Heart Disease ____________________ Ⓨ Ⓝ
    - Anemia & Blood Disorders ___________________ Ⓨ Ⓝ
    - Heart murmur _____________________________ Ⓨ Ⓝ

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30. Do you have any medication allergies (e.g. Lidocaine, penicillin or other antibiotics, pain medications.) If yes, please list and describe your reaction ____________________
31. Do you have any of the below conditions
    - Nervous Disorders ____________ Ⓨ Ⓝ
    - Ulcers ____________ Ⓨ Ⓝ
    - Epilepsy ____________ Ⓨ Ⓝ
    - Fainting Spells ____________ Ⓨ Ⓝ
    - Asthma/Hay Fever ____________ Ⓨ Ⓝ
    - Sinus Trouble ____________ Ⓨ Ⓝ
    - Arthritis ____________ Ⓨ Ⓝ
    - Glaucoma ____________ Ⓨ Ⓝ
    - Diabetes ____________ Ⓨ Ⓝ
    - Hepatitis ____________ Ⓨ Ⓝ
    - Jaundice or Liver Disease ____________ Ⓨ Ⓝ
    - Tuberculosis or Lung Disease ____________ Ⓨ Ⓝ
    - AIDS or HIV ____________ Ⓨ Ⓝ
    - Thyroid Condition ____________ Ⓨ Ⓝ
    - Sexually Transmitted Disease ____________ Ⓨ Ⓝ
    - Mitral Valve Prolapse ____________ Ⓨ Ⓝ
    - Thyroid Disorders ____________ Ⓨ Ⓝ
    - Have you ever been diagnosed with cancer ______ Ⓨ Ⓝ
        - If so, what type ____________
32. Have you ever had radiation treatment ____________ Ⓨ Ⓝ
33. Do you have frequent headaches ____________ Ⓨ Ⓝ
34. Do you have chronic sores of any kind on your skin _______ Ⓨ Ⓝ
35. Do you get short of breath after one flight of stairs ________ Ⓨ Ⓝ
36. Do your ankles swell during the day ____________ Ⓨ Ⓝ
37. Do you get pains in your chest or over your heart ________ Ⓨ Ⓝ
38. Have you been exposed to the HIV virus ____________ Ⓨ Ⓝ
39. Do you have night sweats ____________ Ⓨ Ⓝ
40. Have you ever used intravenous drugs ____________ Ⓨ Ⓝ
41. Do you have swollen lymph nodes ____________ Ⓨ Ⓝ
42. Have you ever had a blood transfusion ____________ Ⓨ Ⓝ
43. Do you smoke ____________ Ⓨ Ⓝ
    - If yes, how many packs per day ____________
44. Do you drink alcohol ____________ Ⓨ Ⓝ
    - If yes, how much ____________

PATIENT DENTAL HISTORY

45. Have you ever had abnormal bleeding following dental extractions, surgery or a cut ____________ Ⓨ Ⓝ
46. Have you ever had a serious problem associated with previous dental treatment ____________ Ⓨ Ⓝ
47. Are you having any discomfort or pain in your mouth _______ Ⓨ Ⓝ
    - If yes, where ____________
48. Are your teeth sensitive to cold, hot, sweets or pressure _____ Ⓨ Ⓝ
49. Do you clench or grind your teeth ____________ Ⓨ Ⓝ
50. Do your jaws ache when you awaken in the morning _______ Ⓨ Ⓝ
51. Have you noticed any loose or shifting teeth ____________ Ⓨ Ⓝ
52. Do you feel that you chew satisfactorily ____________ Ⓨ Ⓝ
53. When you chew, do you have cracking, popping, or pain ___ Ⓨ Ⓝ
54. Are you satisfied with the appearance of your teeth ________ Ⓨ Ⓝ
55. Have you had orthodontic therapy (braces) ____________ Ⓨ Ⓝ
56. Do your gums bleed when you brush ____________ Ⓨ Ⓝ
57. Have you noticed any odor or bad taste in your mouth ______ Ⓨ Ⓝ
58. Do you ever get cold sores ____________ Ⓨ Ⓝ
59. Have you had prior periodontal therapy ____________ Ⓨ Ⓝ
60. Do you wear any removable appliances ____________ Ⓨ Ⓝ

WOMEN ONLY

61. Are you pregnant ____________ Ⓨ Ⓝ
    - Are you nursing ____________ Ⓨ Ⓝ
62. Are you taking birth control pills ____________ Ⓨ Ⓝ
63. Have you reached menopause ____________ Ⓨ Ⓝ
64. Are you undergoing hormone therapy ____________ Ⓨ Ⓝ

SIGNATURE

Patient's Signature____________________

Date____________________

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Handle Me With Care

- ☐ I gag easily.
- ☐ I feel out of control when I am lying down in the dental chair.
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what will say or think about my teeth and my dental hygiene.
- ☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- ☐ Pain relief is a top priority to me.
- ☐ I don't like shots, or I've had a bad reaction to shots.
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sounds of that tool that makes the picking and scraping noise.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ I don't like dental office smells.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I don't like being left alone in the treatment area.
- ☐ I have problems with my back.
- ☐ I don't like the chair tipped back too far.
- ☐ I don't like to see dental instruments.
- ☐ I need to talk to you first, without sitting in the dental chair.

☐ Other concerns I would like to talk about (please specify):

____
____
____
____
____
____
____

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Sleep Questionnaire

Have you ever had an evaluation at a sleep center? ☐Yes ☐No

If you answer yes, continue, otherwise go to the end of the page and sign your name:

Sleep center name, location, and date of your study: ____

____

The evaluation confirmed a diagnosis of: ☐ Mild ☐ Moderate ☐ Severe obstructive sleep apnea

The evaluation showed an RDI of __________________ and an AHI of __________________

CPAP Intolerance (continuous positive airway pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it, then please fill in this section. I could not tolerate the CPAP device due to:

- ☐ Mask leaks
- ☐ I was unable to get the masks to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ Pressure on the upper lip causing tooth related problems
- ☐ A latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night.

Other: ____

What other therapies have you had for breathing disorders? (Weight-loss attempts, smoking cessations for at least 1 month, surgeries, etc):

____
____

Signature: ____ Date:_____________________

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Breathing Questionnaire

Do you snore? ☐Yes ☐No

Do you drool while sleeping? ☐Frequently ☐Sometimes ☐Never

Do you frequently have a blocked/congested nose? ☐Frequently ☐Sometimes ☐Never

Have you ever had trauma to the nose? ☐Yes ☐No

Do you have allergies that cause a stuffy nose? ☐Yes ☐No

Do you have asthma? ☐Yes ☐No

Do you have broken sleep, waking at night for unknown reasons? ☐Frequently ☐Sometimes ☐Never

Please explain/describe: ____

Are you sleepy during the day? ☐Frequently ☐Sometimes ☐Never

Have you been told that you clench/grind your teeth? ☐Yes ☐No

Do you wake with a dry mouth? ☐Yes ☐No

Do you have trouble focusing during the day? ☐Frequently ☐Sometimes ☐Never

Do you have acid reflux/heartburn? ☐Frequently ☐Sometimes ☐Never

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STOP-Bang Questionnaire

☐Yes	☐No	**S**noring? Do you **snore loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
☐Yes	☐No	**T**ired? Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving or talking to someone)?
☐Yes	☐No	**O**bserved? Has anyone **observed** you stop **breathing or choking/gasping** during your sleep?
☐Yes	☐No	**P**ressure? Do you have or are being treated for **high blood pressure**?
☐Yes	☐No	**B**ody mass index more than 35 kg/m^2?
☐Yes	☐No	**A**ge older than 50 years old?
☐Yes	☐No	**N**eck size large? (Measured around Adam's apple) For male, is your shirt collar 17 inches/43 cm or larger? For females, is your shirt collar 16 inches/41 cm or larger?
☐Yes	☐No	**G**ender=Male?

Scoring Criteria:

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Cancellation Policy

RESTORATION AND HYGIENE APPOINTMENTS

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a $75 fee may be assessed to your account. For appointments where a reminder is necessary prior to the weekend, we ask that appointment changes be made by the last business day prior to the scheduled appointment. An appointment that results in a "no-show" or with no notification, a $150 charge will be assessed to the patient.

Note: all cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and the times to properly complete your treatment. A broken appointment is a loss to three people— the patient who missed the valuable time, the patient who could've taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

Signature: ____ Date:__________________

ACKNOWLEDGEMENT AND RELEASE

Insurance

We Provide services for patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company, therefore we do not confirm insurance eligibility or predetermined recommended treatment. We are not preferred providers or members or have any association with any insurance organizations.

Collections

In the event the balance becomes more than 120 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature: ____ Date:__________________

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Medical Information Release Form

HIPAA Release Form

Name: ____ Date of Birth: ____________

Release of Information

[ ] I authorize the release of information including the diagnosis, treatment records; examination rendered to me and claims information. This information may be released to:

- [ ] Spouse/Phone Number: ____
- [ ] Child(ren): ____
- [ ] Other/Phone Number: ____
- [ ] Information is not to be released to anyone

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages sent by Richards Frankel Dentistry

Please call: ☐ Home ☐ Work ☐ Cell

Preferred Number: ____

Signed: ____ Date:____________________

Witness: ____ Date:____________________

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Authorization for Use and/or Release of Information

I authorized employees a Richards Frankel Dentistry (RFD), to share and disclose my protected health information (e.g., name radiographs, progress notes, prescriptions, photographs, images, etc.) with the following individuals or organizations: Educational Journals, Dental Study Clubs, Dental Specialists involved in care, Spear Education, Online Media Sites dedicated to Richards Frankel Dentistry & Educational Publications. I further authorize this information to be shared and discussed with the aforementioned and by myself by, including but not limited to, telephone, facsimile, unencrypted and/or encrypted email, encrypted and/or encrypted portable storage media (e.g., CD, thumb drive, portable hard-drive, etc.) and/or by conventional mail, and I hereby authorize the aforementioned parties to discuss my protected health information (PHI) with employees of (RFD), in the same manner. I understand that some of these listed forms of communication are not secure and may be intercepted by unintended parties. If I have any objection to sending of my PHI through unsecured channels and or specifically desire that my PHI not be shared through an encrypted email, then I would not sign this Authorization. I also authorize the use of my protected health information, including but not limited to my name, photographs, medical histories, and radiographs by the a for mentioned entities for research, educational, and publication purposes without restriction and further consent to the use of any text using in conjunction therewith. I hereby waive any right that I might have to inspect to approve the finished product or products in the text, copy, or other matter which may be used in conjunction therewith, or to the use to which it may be applied. I agree that this release validates use of my photographs, video, audio, and or records in any means, including but not limited to live and or recorded instructional programs, instructional exercises, and promotional materials or advertising. I hereby agree to release, discharge and agree to save harmless (RFD), its heirs, legal representatives and assigns, and all persons acting under its permission or authority, or those for whom it is acting, from any liability by virtue of blurring, distortion, alteration, optical illusion, electronic manipulation, or use in composite form, whether intentional or otherwise, that may occur during publication or in any subsequent processing thereof, including without limitation any claims for libel or invasion of privacy. This authorization for release of information from (RFD), covers all past, present, and future periods of time until January 1, 2050, or when I choose to revoke said authorization in writing.

- I understand that I have the right to revoke this authorization from any or all of the aforementioned entities in writing, at any time, by submitting my written request about each aforementioned entity independently.
- I understand that our revocation is not affected to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of attaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand and agree that this authorization does not qualify me for royalties or financial compensation in any way.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned by any employee of RFD, on whether or not I signed authorization. Enter I understand that information may be used or disclosed pursuant to this authorization it may be disclosed by the recipient and may no longer be protected by federal or state law. protected by federal or state law.

____

Signature of patient or personal representative

____

Relationship to patient, if personal representative or guardian

____________________________ ________________

Printed Name of Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Section A: The Patient.

Name:____________________________________

Address:____

Telephone: ________________________________ Email: _________________________________

Patient Number: ________________________ Social Security Number: ______________________

Section B: Acknowledgement of Receipt of Privacy Practice Notice.

I, ______________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:____ Date: ____________________________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

____

____

Describe the reason why the individual would not sign this form:

____

____

Signature: ____

I attest that the above information is correct.

Signature: _____________________________________ Date: _______________________

Print Name: ____________________________________ Title: _______________________