WATERTOWN Dental Care.com

Patient Registration

Patient's First Name: _____ **M** _____ **Last** _____Today's Date: _____

Birth Date: _____ Age: _____ SSN: _____ Sex: ___ M ___F Full Time Student? ___Yes ___No

Please check one: ___ Single ___ Married ___ Separated ___ Widow Email: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Medical Contacts: Watertown Dental Care coordinates treatment with your other medical providers when needed to ensure maximum benefit to you. Please list your other medical providers.

Primary Care Physician: _____ Sleep Doctor: _____

Other Specialist: _____ Other Specialist: _____

Person Responsible for Account: _____ SSN: _____

Employer: _____ City: _____ State: _____

Address: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How Would You Like To Be Contacted About Appointments? ____Telephone ____ Email /Text

May we contact you via home phone and/or cell phone in regard financial questions and information? _____Yes _____No

How Did You Hear About Our Office? ___ Mailed Offer ___ Newspaper ___ Radio ___ Walk-In ___ Website/Social Media

___ Phone Book ___ Billboard Personal Referral (Name: _____) ___ Special Event (_____)

Dental Insurance Information (Primary Carrier)

Insured's Name: _____

Relationship to Patient: _____

DOB: _____ SSN: _____

Insured's Employer: _____

Insurance Company: _____

Ins. Co. Address: _____

_____

Phone #: _____

Group #: _____

ID #: _____

Secondary Carrier (if applicable)

Insured's Name: _____

Relationship to Patient: _____

DOB: _____ SSN: _____

Insured's Employer: _____

Insurance Company: _____

Ins. Co. Address: _____

_____

Phone #: _____

Group #: _____

ID #: _____

Patient Registration

Financial Policy

Thank you for choosing Watertown Dental Care as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides the very best of care in the most pleasant environment.

In order to make financial arrangements for your treatment, we offer several flexible options. We accept cash, checks, Visa, MasterCard, Discover, and American Express as well as extended payment plans upon credit approval.

Missed Appointments

Please help us to serve you and all of our patients best by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us three business days' notice

Insurance

In most cases, we are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and estimate your portion for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage. You are responsible for knowing your benefit details.

I hereby authorize my insurance company to assign benefits directly to the office of Drs. Darin and Hally Bach, D.D.S., P.C. I understand that I am responsible for all costs of dental treatment. I authorize Watertown Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the information I have provided on the Patient Registration Forms and Dental and Medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I also authorize the use of this signature on all insurance submissions.

Print Name: _____ Signature: _____ Date: _____

Relationship to Patient: ___ Self ___ Parent/Legal Guardian

Summary of Notice of Privacy Practices

Watertown Dental Care keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect, and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice.

You have a right to a copy of this "Notice" Please check your option below:

____ I am requesting a copy of the Watertown Dental Care "Notice of Privacy Practices"

____ I do not wish to receive a copy of the Watertown Dental Care "Notice of Privacy Practices at this time. I reserve the right to request a copy at a later date.

I have had a full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

You May Refuse to Sign this Acknowledgement

Print Name: _____ Signature: _____ Date: _____

Patient Registration

Are you covered by Medicare? ☐ ***No*** ☐ ***Yes, Please complete the following:***

PRIVATE CONTRACT WITH PATIENT
(OPT-OUT OF MEDICARE)

PARTIES & RECITALS:

A. This is a Private Contract between Dr. Darin Bach, DDS, Dr. Hally Bach, DDS, Dr. Clayton Conroy , DDS (DBA: Watertown Dental Care) and _____ (patient) which allows dentist to provide treatment to patient without being subject to Medicare limits. To do so, the law requires dentist to "opt-out" of Medicare and that no Medicare claim be filed for the treatment of patient by dentist.
B. Drs. Bach, Bach & Dr. Conroy are not excluded from Medicare under Sections 1128, 1156 or 1892 or any other section of the Social Security Act.
C. Drs. Bach, Bach, & Conroy have elected to opt-out of the Medicare program, effective May 26, 2015 and will not be eligible to participate in the program again until May 26, 2017.

AGREEMENTS:

A. Patient or his or her legal representative accepts full responsibility for payment of Drs. Bach, Bach, & Conroy's charge for all services furnished by Drs. Bach, Bach, & Conroy.
B. Patient or his or her legal representative understands that Medicare limits do not apply to what Drs. Bach, Bach, & Conroy may charge for services.
C. Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask Drs. Bach, Bach, & Conroy to submit a claim to Medicare
D. Patient or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by Drs. Bach, Bach, & Conroy that would have otherwise been covered by Medicare, if there was no private contract and a proper Medicare claim had been submitted.
E. Patient or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare covered items and services from physicians, dentists, or practitioners who have not opted-out of Medicare, and the patient is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians, dentists or practitioners who have not opted-out. _____**INITIAL HERE**
F. Patient or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
G. Patient or his or her legal representative warrants and represents that Patient does not currently require emergency care services or urgent care services.

EXECUTION AND EFFECTIVE DATE

DENTIST SIGNATURE

PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

Original Contract Must Be Retained by Drs. Bach, Bach, & Conroy.
A Copy Will Be Provided to Patient upon request.

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____	☐	☐
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years _____
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

Sleep Health Questionnaire

☐ M ☐ F

Name | Gender | DOB

Address, City, State, Zip | Weight | Height

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score		

Risk Level	Low	Moderate	High	Severe
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

☐ Hypertension ☐ Snoring ☐ Diabetes

☐ Depression ☐ Grind Teeth ☐ Acid Reflux

☐ Stroke/Heart Disease ☐ Unrefreshed Sleep

☐ Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

Do you use your CPAP less than 5 times a week? ☐ Yes ☐ No

Would you prefer an oral appliance? ☐ Yes ☐ No

Please Present Completed Form, ID & Medical Insurance Card to Front Desk to Allow for Copies

Fax: 888-999-1887 Email: orderentry@ezsleeptest.com Phone: 888-240-7735

For Office Use Only

SHQ Prescription Form

Patient Name _____ Date of Birth _____

Sleep Apnea Management & Risk Assessment Exam: (SAM Exam)

Signs & Symptoms:

- ☐ Hypertension ☐ Loud Snoring ☐ Depression ☐ GERD
- ☐ Bruxism ☐ Diabetes ☐ Narrow or V-shaped upper arch
- ☐ Soft tissue that visually impairs airway ☐ Witnessed choking or gasping for breath
- ☐ Large or scalloped tongue ☐ Neck Size (Male) ≥ 17" or Neck Size (Female) ≥ 16"

Referral Assessment: Consider sleep testing if 1 (or more) boxes below are checked

- Section 1: ☐ PSS Score ≥ 08 (Moderate - Severe)
- Section 2: ☐ 2 (or more) Signs & Symptoms indicated
- Section 3: ☐ "Yes" to 3 (or more) of Sleep History questions

Rx: Baseline home sleep study

☑ Two-night Home Sleep Study or ____-night (Indicate number of nights 1-3)

327.23 to be used to rule out OSA, unless stated differently. If other, please specify:_____

Patient Data / Vital Signs:

Height _____ Weight _____ Neck _____

BP _____ Heart Rate_____ BMI _____

Watertown Dental Care		Darin Bach, DDS	
Group/Practice Name		Doctor's Name	
600 4th St. NE Suite 207 Watertown, SD 57201			
Address, City, State, Zip	Sleep Study Report Delivery Preference: ☐ Email ☐ Fax	smile@watertowndentalcare.com	
605-882-0747			
Phone		Email or Fax #	
M936	1407838741	Kristina (Clinical Coordinator)	RJ
State License #	NPI #	Office Contact & Title	Account Code

Special Notes

Dr. Signature _____ Date _____

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

(Patient to fill out and sign below if sleep test is prescribed)

Consent to Coordinated Care

Sleep disordered breathing (snoring and sleep apnea) can affect a number of systems in the body. Our practice would like to communicate with your doctors about your condition and your treatment progress in order to achieve the best outcome possible. Please provide the names and contact information for your health care team below:

Family Doctor

Name

Phone Fax

Address

City State Zip

Other Doctor

Name

Phone Fax

Address

City State Zip

Release of Information

By signing below, I authorize the practice listed above to release any medical information (i.e. exam findings, diagnosis, treatment programs, etc.) that is requested by:

- My primary care physician, dentist and other health care providers.
- Ez Sleep, diagnostic in-home testing provider.
- Insurance companies or other organizations or entities as may be required by said representatives for payment of claims for services provided by our practice.

Patient Signature _____ Date _____

Fax or email Completed SHQ Forms Page 1 & 2 and include copies of ID & Medical Insurance Cards

Fax: 888-999-1887 Email: orderentry@ezsleeptest.com Phone: 888-240-7735