Adult Intake Forms

GLEN PARK DENTAL
BEAUTIFUL SMILES FOR LIFE

CURRENT DATE: __/__/____

First Name _____ **Last Name** _____ **Middle Initial** _____

Responsible Party (If someone other than the patient)

Name _____

Patient Information

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext. _____ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date _____ Soc Sec # _____

E-mail _____ Spouse Name _____

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: Feet ___ Inches ___ Weight (lbs) _____

Name: _____

Age: _____

Gender: ☐ M ☐ F

Addressograph Stamp - Patient Name, Medical Record Number

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PROGRESS NOTES • ENT CLINIC • PATIENT QUESTIONNAIRE

Date: _____

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit? _____
2. How long have you had this problem? _____
3. How severe is this problem? (Circle) 1 2 3 4 5 6 7 8 9 10 1
   mild very severe
4. How often does this problem occur? ☐ constant ☐ comes and goes
5. What makes it better? _____
6. What makes it worse? _____
7. What other symptoms are you having? _____

PAST MEDICAL HISTORY (Please check any illnesses you have):

☐ High blood pressure	☐ Asthma/Emphysema	☐ Rheumatic fever	Others:
☐ Kidney disease	☐ Stroke, mini-stroke	☐ Sinusitis	_____
☐ Diabetes	☐ Heart disease/Angina	☐ Peptic ulcers	_____
☐ Neck/Back disease	☐ Hepatitis/Liver disease	☐ Thyroid disease	_____

☐ Cancer (please list type and date diagnosed): _____

PAST SURGICAL HISTORY (Please check any surgeries you have had):

☐ Heart bypass/valve	☐ Gall bladder	☐ Prostate removal	Others: _____
☐ Coronary angioplasty	☐ Lung surgery	☐ Colon removal	_____
☐ Carotid artery surgery	☐ Joint replacement	☐ Appendix removal	_____
☐ Vascular bypass	☐ Back surgery	☐ Sinus surgery	_____
☐ Mastectomy	☐ Brain surgery	☐ Tonsillectomy	_____
☐ Heart transplant	☐ Liver transplant	☐ Kidney transplant	_____

MEDICATIONS (List all your current medications and the dose you take):

Medication _____ Dose _____

Medication _____ Dose _____

Medication _____ Dose _____

Medication _____ Dose _____

Do you take Aspirin or Ibuprofen?	☐ Yes	☐ No
Do you take Warfarin (Coumadin)?	☐ Yes	☐ No
Have you taken steroids within the past year?	☐ Yes	☐ No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them):

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

FAMILY HISTORY (Check all illnesses that run in your family):

☐ Hearing loss	☐ Alcoholism	☐ Heart attack	Others _____
☐ High blood pressure	☐ Psychiatric illness	☐ Cancer	_____
☐ Sickle cell anemia	☐ Bleeding problems	☐ Diabetes	_____
☐ Poor circulation	☐ Anesthesia reaction	☐ Stroke	_____

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PROGRESS NOTES • ENT CLINIC • PATIENT QUESTIONNAIRE

Addressograph Stamp - Patient Name, Medical Record Number

SOCIAL HISTORY:

Occupation _____ Marital status: ☐ Married ☐ Single ☐ Divorced
How many children do you have? _____
Have you ever smoked? ☐ Yes ☐ No (☐ cigarettes, ☐ cigar, ☐ pipe)
How much, and for how long have you smoked? _____ packs per day for ____ years.
How much alcohol do you drink each day? _____
List any street drugs you currently use: _____
Do you have any drug addictions? ☐ Yes ☐ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL

☐ Weight loss _____ pounds in the past _____ weeks ☐ Fever, chills

EYES:

☐ Double vision
☐ Loss of vision
☐ Eye pain

ENT:

☐ Hearing loss
☐ Ringing in ears
☐ Dizziness
☐ Ear pain
☐ Ear drainage
☐ Nose drainage
☐ Nasal congestion
☐ Facial pain
☐ Headaches
☐ Sore mouth/throat
☐ Swallowing pain
☐ Voice change
☐ Snoring
☐ Hoarseness
☐ Poor sleep

CARDIOVASCULAR/PULMONARY:

☐ Chest pain
☐ Poor circulation
☐ Shortness of breath
☐ Heart attack
☐ Leg pain during walking
☐ Asthma
☐ Irregular heartbeat
☐ Coughing up blood

GASTROINTESTINAL:

☐ Stomach ulcers
☐ Blood in stool
☐ Nausea/vomiting
☐ Trouble swallowing
☐ Diarrhea
☐ Abdominal pain

GENITOURINARY:

☐ Blood in urine ☐ Pain during urination ☐ Difficulty making urine

MUSCULOSKELETAL:

☐ Neck/Spine surgery ☐ Neck or Back disorder ☐ Arthritis

NEUROLOGICAL:

☐ Stroke
☐ Loss of sensation
☐ Ministroke
☐ Paralysis of an arm or leg
☐ Temporary loss of vision or speech control
☐ Facial paralysis

SKIN:

☐ Skin cancers ☐ Allergy to medical tape, iodine, or latex

PSYCHIATRIC:

☐ Clinical depression
☐ Hallucinations
☐ Schizophrenia
☐ Other psychiatric disorder (list) _____
☐ Anxiety

INFECTIOUS DISEASE:

☐ Hepatitis
☐ TB
☐ HIV/AIDS
☐ Mononucleosis

I have personally reviewed this history and review of systems:

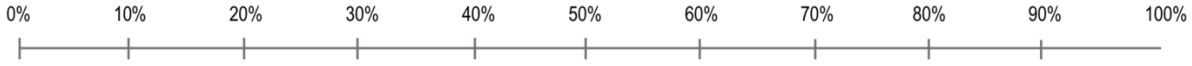
_____ _____
Attending Physician Signature Date

Complete the following questions, choosing from 0-4 for each row/question

	Question	0	1	2	3
Functional Breathing	Do you mouth breathe while awake?	Rarely to never	Sometimes	Often	Almost always
	Do you mouth breathe while asleep?	Rarely to never	Sometimes	Often	Almost always
	Do you have dry or chapped lips?	Rarely to never	Sometimes	Often	Almost always
	Do you sigh or yawn frequently?	Rarely to never	Sometimes	Often	Almost always
	Do you ever feel short of breath?	Rarely to never	Sometimes	Often	Almost always
	Do you find it difficult to breathe while wearing a face mask?	Rarely to never	Sometimes	Often	Almost always
Pulmonary/ Cardiovascular	Do you experience pain, pressure, or tightness in the chest?	Rarely to never	Sometimes	Often	Almost always
	Do you experiencean irregular, fast, or racing heartbeat?	Rarely to never	Sometimes	Often	Almost always
Conditions	How frequently do you get sick?	Rarely to never	Sometimes	Often	Almost always
	Have you experienced or been diagnosed with any of the following conditions?	None	Snoring	Upper Airway Resistance Syndrome	Obstructive Sleep Apnea
Posture	Do you ever slouch?	Rarely to never	Sometimes	Often	Almost always
	Do you have any neck or shoulder tension?	Rarely to never	Sometimes	Often	Almost always
Psychosocial (CNS)	Do you ever feel stressed or anxious?	Rarely to never	Sometimes	Often	Almost always
	Do you experience panic attacks?	Rarely to never	Sometimes	Often	Almost always
	Do you ever have difficulty concentrating?	Rarely to never	Sometimes	Often	Almost always
Tongue Resting Position	Where do you feel that your tongue rests in your mouth?	Entire tongue usually rests up along palate.	The tip of the tongue usually rests up on the palate.	The tongue usually rests in the middle against the teeth.	The tongue usually rests on the floor of the mouth
Orofacial Function	Do you experience headaches?	Rarely to never	Sometimes	Often	Almost always
	Do you experience pain in your Temporomandibular Joint (TMJ)?	Rarely to never	Sometimes	Often	Almost always
	Do you clench or grind your teeth?	Rarely to never	Sometimes	Often	Almost always

Nasal Obstruction Visual Assessment Scale (NO-VAS)

Rate from 0-100 how difficult it is to breathe through the nose (usually or most commonly)? ____%



Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0=Would never dose 1=Slight chance of dozing 2=Moderate chance of dozing 3=High chance of dozing

Question	Score				
Sitting and Reading	**0**	**1**	**2**	**3**	____
Watching Television	**0**	**1**	**2**	**3**	____
Sitting inactive in a public place (theatre/meeting)	**0**	**1**	**2**	**3**	____
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**	____
Lying down to rest in the afternoon	**0**	**1**	**2**	**3**	____
Sitting and talking to someone	**0**	**1**	**2**	**3**	____
Sitting quietly after lunch (with no alcohol)	**0**	**1**	**2**	**3**	____
In a car, while stopped in traffic	**0**	**1**	**2**	**3**	____
TOTAL:					

Fatigue Severity Scale Questionnaire (FSS)

Instructions: Circle the number that best represents your response to each question.
Scoring Range: 1=Strongly Disagree with the statement to 7=Strongly Agree with the statement.

During the past week, I have found that:	Score							
1. My motivation is lower when I am fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
2. Exercise brings on my fatigue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
3. I am easily fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
4. Fatigue interferes with my physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
5. Fatigue causes frequent problems for me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
6. My fatigue prevents sustained physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
7. Fatigue interferes with carrying out certain duties and responsibilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
8. Fatigue is among my three most disabling symptoms.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
9. Fatigue interferes with my work family, or social life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	____
FSS Scoring: Add up circled numbers and divide by 9:								

The Self Evaluation of Breathing Questionnaire

Scoring: (0) never/not true at all; (1) occasionally/a bit true; (2) frequently-mostly true; and, (3) very frequently/very true

1. I get easily breathless out of proportion to my fitness	0	1	2	3
2. I notice myself breathing shallowly	0	1	2	3
3. I get short of breath reading and talking	0	1	2	3
4. I notice myself sighing	0	1	2	3
5. I notice myself yawning	0	1	2	3
6. I feel I cannot get a deep or satisfying breath	0	1	2	3
7. I notice that I am breathing irregularly	0	1	2	3
8. My breathing feels stuck or restricted	0	1	2	3
9. My ribcage feels tight and cannot expand	0	1	2	3
10. I notice myself breathing quickly	0	1	2	3
11. I get breathless when I'm anxious	0	1	2	3
12. I find myself holding my breath	0	1	2	3
13. I feel breathless in association with other physical symptoms	0	1	2	3
14. I have trouble coordinating my breathing when I am speaking	0	1	2	3
15. I can't catch my breath	0	1	2	3
16. I feel that the air is stuffy, as if not enough air is in the room	0	1	2	3
17. I get breathless even when I am resting	0	1	2	3
18. My breath feels like it does not go in all the way	0	1	2	3
19. My breath feels like it does not go out all the way	0	1	2	3
20. My breathing is heavy	0	1	2	3
21. I feel that I am breathing more	0	1	2	3
22. My breathing requires work	0	1	2	3
23. My breathing requires effort	0	1	2	3
24. I find myself breathing through my mouth during the day	0	1	2	3
25. I breathe through my mouth at night while I sleep	0	1	2	3
Total				
A score greater than 11 may indicate problems with your breathing.				

Which position do you typically sleep in ?

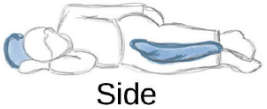
Rarely Often Always

Stomach

Rarely Often Always

Back

Rarely Often Always



Side

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HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. HIPAA provides certain rights and protections to you as the patient on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. We balance these rights with our goal of providing you with quality professional service and care. As such, we have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints to the attention of the office manager or physician.

6. Your confidential information will not be used for marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may modify any of these provisions to better serve the needs of the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth In the HIPAA INFORMATION FORM and any subsequent changes in office policy.

Signed: _____ Date: ____/____/_____

Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

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Medical Information Release Form (HIPAA Release Form)

Name: _____ **Date of Birth:** _____/____/_____

Release of Information

☐ **I hereby authorize** Glen Park Dental and affiliates, employees, or agents to release any personal health information (e.g., information relating to the diagnosis, records, treatment, claims payment, and health care services) provided or to be provided to me to (please print provider's name(s) and contact information):

- ☐ Parent/ Spouse / Relative_____
- ☐ Referring Provider _____
- ☐ Primary Care Doctor_____
- ☐ Other Consultants_____

_____
[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]

☐ **I do not authorize** Glen Park Dental or affiliates to release any medical information.

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

Messages

Please call ☐my home ☐my work ☐my cell Number:_____

If unable to reach me:

- ☐you may leave a detailed message
- ☐please leave a message asking me to return your call
- ☐_____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

GLEN PARK DENTAL
BEAUTIFUL SMILES FOR LIFE

AUTHORIZATION AND CONSENT TO USE PHOTOGRAPH OR VIDEO RECORDINGS

PATIENT NAME: _____

I, the undersigned, do hereby consent and agree that Glen Park Dental and its employees, and/or agents have the right to take photographs, video, or digital recording of me or my dependent and to use these in any and all media, including educational materials, informational and conference presentations, social media, website, before/after photos etc.

(Mark your choice below)

- ☐ **YES** – Including full face.
- ☐ **YES** – But please exclude any recognizable facial features.
- ☐ **NO** – Photographs may only be used for medical record keeping and treatment planning only.

I further consent that my name and identity may be revealed therein or by descriptive text or commentary. (Mark your choice below)

- ☐ **YES** – Use my name.
- ☐ **NO** – I prefer to remain anonymous .

AUTHORIZATION AND CONSENT TO USE MEDICAL RECORDS FOR RESEARCH PURPOSES

Glen Park Dental is proud to be an international leader in research relating to sleep, breathing, tongue-tie, maxillofacial development and airway health.

(Mark your choice(s) below)

- ☐ I consent for my anonymous medical records to be used for quality improvement and research purposes.
- ☐ I am interested in participating in research projects. Please send me any information for research that may be available.
- ☐ I do not wish to participate in any research.

Name of Authorizing Individual:_____ Relationship to Patient: _____

Signature: _____ Date:_____

Witness: _____ Date:_____

If this release is obtained from a patient under the age of 18, then the signature of the parent or legal guardian is required.

GLEN PARK DENTAL
BEAUTIFUL SMILES FOR LIFE

Treatment Fee Schedule:
Fee-for-Service Payment Plan and Maximum Out-of-Pocket Costs

Thank you for choosing our practice for your healthcare needs. We greatly appreciate your trust and confidence in our expertise and consider it an honor and privilege to help you and your family.

We chose to build a patient-centered model for our practice that does not allow insurance companies to dictate the care we provide. This means that we are not contracted with insurance carriers. Because of this, we collect payment directly from the patient during the time of your visit.

Our office does, however, provide concierge billing services and will work directly with your insurance company to file for any out of network benefits your insurance company offers,so that your insurance company may reimburse you directly according to the terms of your policy.

Our consultation and follow-up service fees are in accordance with the following schedule. Because most insurance companies provide reimbursement based on a fee-for-service payment plan, you may notice some variance between the amount billed to your insurance company and the fees we collect from you as a patient or parent.

Because we desire to keep our service affordable and understand the increasing burden of healthcare expenses, our policy is to cap the maximum costs to our families as much as possible. In some cases, if additional services are rendered, we aim to provide these services as a courtesy to our families, and we then seek reimbursement for the additional services from your insurance company only.

Below is a breakdown of care we provide and its related cost to you:

Procedure	Fee to Insurance	Your Fee
In-Person Comprehensive Consultation	$350	$350
ZOOM Consultation	$350	$350
Scoping (billed as surgical)	$695	$0
CT Scan	$695	$220
BeamReaders or Radiology Interpretation	Not Applicable	$200
Sleep Study and Interpretation (if needed)	$900	$495
Frenuloplasty (In Office/Surgery Center)	$695-$4000	$695-$2595
Other In Office Procedures	$1500-$4000	$995-$3500
Operating Room Surgical Procedure	$3500-$15,000	$1995-$9500
Myofunctional Therapy Consultation	$450	$250
Myofunctional Therapy Session	$300	$200

We hope this information provides clarity and reassurance to you about our billing practices. Please let us know if there are any additional questions or concerns.

I have read the above information and have had the opportunity to seek answers to any remaining questions. I further understand that I will not be reimbursed for services covered by my insurance company that were not charged to me as the responsible party.

Patient Name _____ Responsible Party Signature _____ Date _____