Welcome To Our Practice

We would like to thank you for allowing us to treat you as a patient. We are pleased to meet any dental needs you or your family have. We will **always** do our best to give you the most up to date and professional care available. To avoid any confusion, we have listed below some of our office policies and procedures.

- As a courtesy Colson Dental Group will file your dental claim with your insurance company. Your deductible and co-pay or any portion not covered by your insurance company is due at the time of service. For those patients without insurance coverage, **you will be responsible for your payment in full on the day of treatment.**

- **Broken appointments are very costly and inconvenient.** Please inform us at least twenty-four (24) hours in advance if you are unable to keep your appointment. Broken appointments will lead to you and your family being dismissed from our practice. Any non confirmed appointment may be rescheduled.

- If you have Medicaid**, you must have your current Medicaid card with you**. Also, if you are twenty-one (21) years of age or older you are responsible for the $3.00 co-pay. If you do not have a current card we reserve the right to reschedule your appointment.

- If you are more than fifteen (15) minutes late for your appointment, you may be rescheduled for another day. This will be considered a broken appointment.

- All patients under the age of eighteen (18) will not be seen or treated, in the absence of a parent or legal guardian, without a signed consent form.

- You are responsible to pay the cost of collecting any debt owed on your account. This includes all attorney's fees, late fees, and interest to be charged at one percent per month.

By signing below you have read and understood our Notice of Privacy Practices that is posted in our waiting area. A copy of this agreement is available upon request.

Your cooperation is greatly appreciated in this matter. If you have any questions, please feel free to ask our staff.

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Signature ***Date***

Colson DENTAL GROUP

Adult Medical History Questionnaire

Patient Information

Full Name:				☐ Male ☐ Female	
Address:					
City:		State:		Zip:	
Telephone:		Work Cell:			
E-mail :					
Social Security # :		Drivers License #:			
Employer:		Occupation:			
Date of Birth:	Age:	Height:		Weight:	
Emergency Contact:		Phone:			

Responsible Party

Full Name:		Relationship:			
Address:		Date of Birth:			
City:	State:		Zip:		
Employer:		Phone:			
Social Security # :		Drivers License #:			
Method of Payment:	☐ Cash ☐ Visa/MC ☐ Check ☐ Insurance				

Insurance

Name of Insured:		Date of Birth:			
Social Security #:		Employer:			
Insurance Company:					
Address:					
Phone:	Group #:		Policy #:		

If you have additional dental insurance please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please understand that your insurance is a contract between you, your employer and your insurance company. Thus we cannot speak on behalf of your insurance company. We will gladly act as your advocate but we cannot be responsible for settling any disputed claims or coverage. **Please remember that you are ultimately responsible for your bill.**

If we do not receive payment from your insurance carrier within forty-five (45) days we will notify you. Failure of your insurance carrier to reimburse our office within sixty (60) days will result in our billing you directly for the remaining balance.

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Signature of Patient or Responsible Party: ***Date***

How did you select Colson Dental Group? *Please check the one that applies to you:*

- ☐ Family Member/Friend Referral _____
- ☐ ColsonDentalGroup.com (website)
- ☐ Office Appearance
- ☐ Your Dental Insurance Co.
- ☐ Dentist Referral _____
- ☐ Accept NC Healthchoice
- ☐ Health & Science Flyer
- ☐ www.Wechsptsa.org
- ☐ Company Sign on Sunnybrook
- ☐ Internet Referral
- ☐ Google Search
- ☐ Bing Search
- ☐ Yahoo! Search
- ☐ Yellow Pages
- ☐ Other Printed AD
- ☐ Wcpss.net Career Advisory (site)
- ☐ YP.com
- ☐ Accepts Medicaid

Patients Medical History

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. The following questions must be answered honestly so that our office can provide you with the best possible care. If we determine that questions have not been answered honestly you will be dismissed from our practice.

Please Select the Correct Response

Are you **allergic** to, or have you had unusual reactions to any of the following?

Select all that apply:

☐ Penicillin	☐ Aspirin	☐ Iodine	☐ Codeine
☐ Sulfa Drugs	☐ Barbiturates	☐ Erythromycin	☐ Latex

Have you ever been seriously ill? ☐ Yes ☐ No

Have there been any changes in you general health recently? ☐ Yes ☐ No

Are you currently being treated by a medical Doctor? ☐ Yes ☐ No

If yes, what is the Doctors Name? _____

Phone Number? _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes please list _____

Have you ever been hospitalized? ☐ Yes ☐ No

When? _____

An emergency existed & a signature was not possible at the time.

If you could change anything about your smile, what would it be?

_____

Have you ever had a major operation? ☐ Yes ☐ No

Have you had a physical exam in the last year? ☐ Yes ☐ No

Have you ever had to take antibiotics before having dental work? ☐ Yes ☐ No

Do you have artificial joints or heart valves? ☐ Yes ☐ No

Do you have chest pains upon exertion? ☐ Yes ☐ No

Have you ever had x-rays for a tumor, growth or any other condition? ☐ Yes ☐ No

Have you ever been exposed to the AIDS virus (HIV)? ☐ Yes ☐ No

Would you consent to a blood test (at our expense) if the Doctor or staff member suffers a needle stick or puncture wound? ☐ Yes ☐ No

Are you currently using any recreational drugs such as cocaine? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever experienced an unusual reaction to dental anesthetic? ☐ Yes ☐ No

Have you ever been told that any of the following pertain to you?

			Date of the last episode				**Date of the last episode**
Mitral Valve Prolapse	☐ Yes	☐ No	_____	Heart Murmur	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Heart Attack	☐ Yes	☐ No	_____	Herpes	☐ Yes	☐ No	_____
Hives/Skin Rash	☐ Yes	☐ No	_____	Epilepsy	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____	Anemia	☐ Yes	☐ No	_____
AIDS	☐ Yes	☐ No	_____	Rheumatic Fever	☐ Yes	☐ No	_____
Hepatitis	☐ Yes	☐ No	_____	Tuberculosis	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____	Jaundice	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____	Hay Fever	☐ Yes	☐ No	_____
Venereal Disease	☐ Yes	☐ No	_____	Kidney Disease	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____	Mental Health	☐ Yes	☐ No	_____

Do you bleed for a long time when you cut yourself? ☐ Yes ☐ No _____

Do you have frequent or severe headaches? ☐ Yes ☐ No _____

Do you have sinus trouble? ☐ Yes ☐ No _____

Do you have painful or swollen joints? ☐ Yes ☐ No _____

Do you have frequent cold sores or canker sores? ☐ Yes ☐ No _____

Do you have complaints about your ears/hearing? ☐ Yes ☐ No _____

If you could change anything about your smile, what would it be? _____

Do you have frequent colds? ☐ Yes ☐ No _____

Are you nervous? ☐ Yes ☐ No _____

Have you lost or gained weight in the last few months? ☐ Yes ☐ No _____

Has your appetite changed recently? ☐ Yes ☐ No _____

Are there any foods that you cannot eat? ☐ Yes ☐ No _____

For Women Only

Are you pregnant? ☐ Yes ☐ No

Are you taking oral contraceptives (birth control pills)? ☐ Yes ☐ No

Women who take oral contraceptives (birth control pills) should take extra precautions when taking antibiotics. Antibiotics can cause failure of birth control pills which could result in pregnancy.

Patient Dental History

When was the last time you visited the dentist? _____Where? _____

When was the last time you had your teeth cleaned? _____

Do you usually see a dentist every six (6) months ☐ Yes ☐ No

May we take dental x-rays if they are needed? ☐ Yes ☐ No

Do you have fluoride in your drinking water? ☐ Yes ☐ No

Do you take a fluoride supplement? ☐ Yes ☐ No

Have you ever had periodontal (gum) treatment? ☐ Yes ☐ No

Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No

Do you floss regularly? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

What kind of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

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Signature ***Date***

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name: _____ Height: _____ Weight:_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation		Chance of Dozing
1.	Sitting and reading	
2.	Watching TV	
3.	Sitting inactive in a public place *(e.g. 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	

Have you ever been diagnosed with:

1. Impaired Cognition *(i.e. difficulty concentrating or thinking)* ☐ Yes ☐ No
2. Mood Disorders/Depression ☐ Yes ☐ No
3. Insomnia ☐ Yes ☐ No
4. Hypertension *(high blood pressure)* ☐ Yes ☐ No
5. Ischemic Heart Disease *(Coronary Artery Disease/Atherosclerosis)* ☐ Yes ☐ No
6. History of Stroke ☐ Yes ☐ No
7. Sleep Apnea ☐ Yes ☐ No
If **yes**: Did you try to use CPAP ☐ Yes ☐ No
8. TMJ problems significant enough to require treatment ☐ Yes ☐ No
9. Gastric Reflux *(GERD)* or Heartburn ☐ Yes ☐ No

Are you aware of (or have you been told):

1.	Snoring on a regular basis	☐ Yes	☐ No
2.	Feeling tired or fatigued on a regular basis	☐ Yes	☐ No
3.	Clenching or grinding your teeth (bruxism)	☐ Yes	☐ No
4.	Having frequent headaches	☐ Yes	☐ No
5.	Your neck size being > 17 inches (male) or > 16 inches (female)	☐ Yes	☐ No
6.	Anyone in your family having sleep apnea	☐ Yes	☐ No
7.	Stopping breathing when sleeping/awakening with a gasp	☐ Yes	☐ No

For children only **(filled out by parent or guardian)**

Are you aware of your child:

1.	Snoring/noisy breathing while sleeping	☐ Yes	☐ No
2.	Grinding his or her teeth	☐ Yes	☐ No
3.	Wetting the bed	☐ Yes	☐ No
4.	Having difficulty in school/learning	☐ Yes	☐ No
5.	Being treated for ADD or ADHD	☐ Yes	☐ No
6.	Breathing primarily through their mouth	☐ Yes	☐ No
7.	Having frequent nightmares/night terrors	☐ Yes	☐ No
8.	Having frequent ear aches	☐ Yes	☐ No

Dental Exam Findings:

☐ **Evidence of Bruxism**	☐ **Scalloping of the tongue**	☐ **Crowded airway**
☐ **Tori or Bone Loss**	☐ **Anterior wear**	☐ **Retrognathia / Class II**