Gary J. Jacky, DMD

Account # ___/___/___/___/___/___/___ Date ___/___/___

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ M. INITIAL _____ SEX _____ DATE OF BIRTH: MO. ____ DAY ____ YEAR ____

CHECK ONE: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

ADDRESS _____ SOCIAL SECURITY # _____

CITY, STATE, ZIP _____ DRIVERS LICENSE # _____

HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

EMAIL ADDRESS _____ EMPLOYER NAME _____

WOULD YOU LIKE TO RECIEVE EMAIL/TEXT REMINDERS? _____ OCCUPATION _____

NEAREST RELATIVE (NOT LIVING WITH YOU) _____ CITY _____ ( ) PHONE # _____

SPOUSE OR PARENT INFORMATION

LAST NAME _____ FIRST _____ M.INIT. _____ SEX _____ DATE OF BIRTH MO. ____ DAY ____ YR. ____

ADDRESS _____ SOCIAL SECURITY # _____

CITY, STATE, ZIP _____ DRIVER'S LICENSE # _____

HOME PHONE # _____ WORK PHONE # _____

EMPLOYER NAME _____ OCCUPATION _____

INSURANCE

PRIMARY CO. NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

GROUP NAME _____ GROUP # _____ SUBSCRIBER # _____

SECONDARY CO. NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

GROUP NAME _____ GROUP # _____ SUBSCRIBER # _____

SIGNATURE OF RESPONSIBLE PARTY

How did you hear of this office?

Accounts over 60 days will be charged an interest fee of 1.5% per month for an annual fee of 18%. If you have insurance coverage we will bill the insurance company for you, but regardless of your coverage you are responsible for the balance of your bill.

_____

PATIENT SIGNATURE

REV 10/92

DENTAL HEALTH HISTORY

Previous Dentist _____ Phone No. _____ Date of last visit _____

	Yes	No
Are you apprehensive about dental treatment?	❑	❑
Have you had problems with previous dental treatment?	❑	❑
Do you gag easily?	❑	❑
Do you wear dentures?	❑	❑
Does food catch between your teeth?	❑	❑
Do you have difficulty in chewing your food?	❑	❑
Do you chew on only one side of your mouth?	❑	❑
Do you avoid brushing any part of your mouth because of pain?	❑	❑
Do your gums bleed easily?	❑	❑
Do you gums bleed when you floss?	❑	❑
Do your gums feel swollen or tender?	❑	❑
Have you ever noticed slow healing sores in or about your mouth?	❑	❑
Are your teeth sensitive?	❑	❑
Do your feel twinges of pain when your teeth come in contract with:		
Hot foods or liquids?	❑	❑
Cold foods or liquids?	❑	❑
Sours?	❑	❑
Sweets?	❑	❑
Do you take fluoride supplements?	❑	❑
Are you dissatisfied with the apperance of your teeth?	❑	❑
Do you prefer to save your teeth?	❑	❑
Do you want complete dental care?	❑	❑
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	❑	❑
Do you clench or grind you jaws frequently?	❑	❑
Do your jaws ever feel tired?	❑	❑
Does your jaw get stuck so that you can't open freely?	❑	❑
Does it hurt when you chew or open wide to take a bite?	❑	❑
Do you have earaches or pain in front of the ears?	❑	❑
Do you have any jaw symptoms or headaches upon awaking in the morning?	❑	❑
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	❑	❑
Do you find jaw pain or discomfort extremely frustrating or depressing?	❑	❑
Do you take medication or pills for discomfort (pain relievers, musckle relaxants, antidepressant)?	❑	❑
Do you have a temporomandibular (jaw) disorder (TMD)?	❑	❑
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	❑	❑
Are you unable to open your mouth as far as you want?	❑	❑
Are you aware of an uncomfortable bite?	❑	❑
Have your had a blow to the jaw (trauma)?	❑	❑
Are you a habitual gum chewer or pipe smoker?	❑	❑

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No
Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No	Anaphylaxis	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Anemia	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No				

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

STATEMENT OF PRIVACY PRACTICES

Perrinville Family Dentistry
7533 Olympic View Drive, # C
Edmonds, Washington
425-670-2392

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Perrinville Family Dentistry

Perrinville Family Dentistry
7533 Olympic View Drive, # C
Edmonds, Washington 98026
425-670-2392

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Perrinville Family Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Perrinville Family Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐	**YES**	☐	**NO**
SPOUSE ONLY	☐	**YES**	☐	**NO**
OTHER (***PLEASE SPECIFY***):	☐	**YES**	☐	**NO**

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained		
PROVIDED PRIOR TO TREATMENT?	☐ **YES** ☐ **NO**	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):

Perrinville Family Dentistry

"COMMITMENT POLICY"

Commitment to Treatment

We believe necessary treatment should be completed in a timely manner. Incomplete treatment leads to complications, possible pain and tooth loss for the patient. It is our goal to save your teeth and maintain your dental health. The dentist and patient must have mutual goals and a reasonable time frame to successfully complete treatment.

Appointment Commitment

We reserve the time for each patient in our practice, and make every effort to respect your time by running on schedule as much as possible. For your convenience, we attempt to give all patients a courtesy reminder call. Please be sure to keep your contact information current with our office so that we may reach you.

We request any changes to your scheduled appointment be made 48 hours in advance. **FAILURES TO GIVE 48 HOURS NOTICE FOR THE FOLLOWING WILL RESULT IN A CHARGE OF 50.00 PER HOUR OF APPOINTMENT TO YOUR ACCOUNT:**

- "No Show" for a confirmed appointment
- Same day cancellation or reschedule

Financial Commitment

After your initial exam, the doctor will review your radiographs and, using his best judgment, will propose a treatment plan for you. Together, you and the doctor will discuss his findings and our financial managers will then present the estimated fees. For those patients with insurance, we accept most dental plans and will gladly submit a dental claim on your behalf. **HOWEVER, IN THE EVENT THAT YOUR INSURANCE CARRIER DOES NOT PAY FOR A CLAIM, THE PATIENT/GUARANTOR IS ULTIMATELY RESPONSIBLE FOR CHARGES INCURRED FOR SERVICES RENDERED.**

All co-pays and deductibles are due at the time services are rendered.

A 35.00 fee will be charged to your account for all returned checks.

The patient/guarantor acknowledges and agrees to the terms described above

_____ _____

Patient/Guarantor Signature Date

Sleep Screening Questionnaires

Please answer the questions below to help us assess for possible sleep apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep apnea can increase your risk for many health conditions. It can also increase your risk for breathing problems after surgery.

Name _____ Date _____

DOB _____ Height _____ Weight _____

	Yes	No
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐
Are you currently being treated for OSA?	☐	☐
Are you aware of a family history of OSA?	☐	☐
Are you aware of clenching or grinding your teeth at night?	☐	☐

ESS: 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 theatre 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 in a lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____

STOP - BANG

			Yes	No
1.	**S**nore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	☐	☐
2.	**T**ired	Do you often feel tired, fatigued or sleepy during daytime?	☐	☐
3.	**O**bstruction	Has anyone observed you stop breathing during your sleep?	☐	☐
4.	**P**ressure	Do you have or are you being treated for high blood pressure?	☐	☐
5.	**B**MI	Is your body mass index greater than 28?	☐	☐
6.	**A**ge	Are you 50 years old or older?	☐	☐
7.	**N**eck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	☐	☐
8.	**G**ender	Are you a male?	☐	☐

_____

Patient Signature

Perrinville Family Dentistry

Gary J Jacky DMD INC PS

CBCT Consent Form

A CBCT scan, also known as a Cone Beam Computed Tomography, is an x-ray technique that produces 3-D images of your skull that allows visualization of internal bony structures in cross-section rather than as overlapping images typically produced by conventional x-ray exams. CBCT scans are primarily used to visualize bony structures, such as teeth and your jaws, not soft tissue such as your tongue or lips.

Advantages of a CBCT scan over conventional x-rays: A conventional x-ray of your mouth limits your dentist to a two-dimensional or 2D visualization. Diagnosis and treatment planning can require a more complete understanding of complex three-dimensional or 3D anatomy.

Advantages of CBCT scans include:

A) Higher accuracy when planning implant and other surgeries

B) Greater chance for diagnosing conditions such as vertical root fractures and endodontic pathology that can be missed on conventional x-rays

C) Greater chance of providing images and information which may result in the patient avoiding unnecessary, and sometimes invasive, dental treatment

D) Better diagnosis of third molar (wisdom teeth) positioning in proximity to vital structures such as nerves and blood vessels prior to removal

E) The CBCT scan enhances your dentist's ability to see what needs to be done before treatment is started.

F) Enhanced patient safety, more predictable outcomes, less discomfort, and faster treatments.

Radiation: CBCT scans, like conventional x-rays, expose you to radiation. The amount of radiation you will be exposed to is the equivalent to what you would receive from several days of normal background environmental radiation. The dose of radiation used is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. However, all radiation is linked with a slightly higher risk of developing cancer (3 in 1,000,000). But the advantages of a CBCT scan outweigh this disadvantage.

Pregnancy: Women who are pregnant should not undergo a CBCT scan due to the potential danger to fetus. Please tell the dentist if you are pregnant or are planning to become pregnant.

Diagnosis of non-dental conditions: While part of your anatomy beyond your mouth and jaw may be evident from the scan, your dentist may not be qualified to diagnose conditions that may be present in those areas. If any abnormalities, asymmetries, or common pathologic conditions are noted upon the CBCT scan, it may become necessary to send the scan to an Oral and Maxillofacial Radiologist for further diagnosis. If this occurs, we can submit to a radiologist on your behalf for an additional charge of $85.00. We can also bill this service to your medical insurance with your consent in an attempt to have the service reimbursed to you.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE TO ACCEPT THE RISKS AND ADVANTAGES NOTED I, _____ being 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I acknowledge that I had a full opportunity to discuss the matter with my dentist. All my questions have been answered. I therefore give my consent to have a CBCT completed by the office of Perrinville Family Dentistry.

Patient/Guardian Signature: _____ **Date:** _____