Your full name: Mr., Mrs., Miss, Ms., Dr. _____ Age:_____ D.O.B:_____

By what name would you prefer to be called in our office? _____ Social Security number: _____

Residence Address:_____ City: _____ Zip:_____

Residence Phone:_____ Business Phone:_____

Cell Phone: _____ Email Address: _____

Employer Name and Address:_____

Dental insurance coverage, if any: _____

If covered by spouse's/parent's insurance, list their name and employer's name and address:_____

What is your present dental problem as you understand it? _____

Do you clench or grind your teeth? _____ During Day? _____ During Night? ____

Have you ever had an unpleasant dental experience? _____

Are you having any discomfort or pain? If so, where?_____

Are you concerned about bad breath (Halitosis)?_____

Do you consider snoring a problem?_____

Family Dentist's Name:_____ **Referred here by:**_____

Physician's Name:_____ **Physician's Address:**_____

	Yes	No
1. Are you now or have you been in the last five years under the care of a physician? If so, please explain: _____ Date of last complete physical:_____	❑	❑
2. Have you ever had any serious illness? If so, please explain: _____	❑	❑
3. Have you ever been hospitalized? Please explain:_____	❑	❑
4. Are you taking any medications (vitamins, medicines or drugs; at the present time?) Please list them:_____	❑	❑

Please circle what applies to you:

5. Have you ever had or been treated for HEART TROUBLE, RHEUMATIC FEVER, ABNORMAL BLOOD PRESSURE, THYROID, STOMACH ULCER, HIV DISEASE, ASTHMA, ALLERGIES, DIABETES, EPILEPSY, GALL BLADDER, TUBERCULOSIS, KIDNEY OR LIVER INVOLVEMENTS, JOINT PROBLEMS, ANEMIA, HYSTERECTOMY, BLOOD DISORDERS, CANCER, HEPATITIS, TRANSFUSION.		
5a. Has any blood relative had diabetes?_____Who:_____	❑	❑
6. Have you ever had any adverse effects or allergic reactions from any anaesthetic, antibiotic or any other medicine? _____ Please list which ones: _____	❑	❑
7. Has your weight changed recently? _____Up or Down? _____How many pounds? _____	❑	❑
7a. Do you have profuse sweating at night? _____	❑	❑
8. Have you ever had a bleeding problem? Please explain: _____	❑	❑
9. Do you bruise or swell easily?_____	❑	❑
10. Have you had prolonged unexplained fever in the last year? _____	❑	❑
11. Do you get infections easily? Please explain: _____	❑	❑
12. Do you have a heart murmur?_____	❑	❑
13. Do you have persistent diarrea? _____	❑	❑
14. Have you had a joint replacement, such as a hip or knee?_____	❑	❑

15. NUTRITION: How much do you smoke?_____ How many cups of coffee or tea do you drink? _____ How much alcohol each day?_____ sweets?_____ Do you have trouble sleeping?_____ vitamins?_____ Do you eat breakfast?_____

What is your biggest concern? _____

_____

DATE _____ SIGNED _____

INSURANCE INFORMATION NEEDED FOR NEW PATIENTS

If patient covered under spouse, please complete bottom portion only

Patient's Name _____

Date of Birth _____ Social Security No. _____

Insurance Company _____

Address _____

_____ Zip _____

Employer _____

Address _____ Zip _____

Group Number _____

Spouse's Insurance Information

Spouse's Name _____

Date of Birth _____ Social Security No.: _____

Insurance Company _____

Address _____ Zip _____

Employer _____

Address _____ Zip _____

Group Number _____

Assignment of Benefits

I, _____ hereby assign all medical and dental benefits to myself or the noted provider for professional services rendered and I authorize the release of any dental information necessary to process this claim. This assignment will remain in-effect until revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. This office makes no representation as to what, if any, portion of this bill will be paid by insurance. The entire bill for services rendered is the responsibility of the patient. A 1% finance charge will apply to any unpaid balance over 90 days. I understand I will be responsible for any costs and expenses associated with collection, including attorney fees.

Signature _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect APRIL 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a written request to obtain access to your medical information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

You May Refuse To Sign This Acknowledgement

I _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

This Form is Educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002).

MARTIN C. NAGER, D.M.D.
BRENDA R. PIERCE, D.D.S.

67 Jefferson Boulevard • Warwick, RI 02888
118 Point Judith Road • Narragansett, RI 02882

Periodontics
Temporomandibular Joint Dysfunction
Dental Implants

Screening Questionnaire for Temporomandibular Joint Disorders

	YES	NO
1 Do you have difficulty or pain, or both, when opening your mouth, as for instance, when yawning?	☐	☐
2. Does your jaw get "stuck," "locked," or "go out"?	☐	☐
3. Do you have difficulty or pain, or both, when chewing, talking, or using your jaws?	☐	☐
4. Are you aware of noises in the jaw joints?	☐	☐
5. Do you have pain in or about the ears, temples, or cheeks?	☐	☐
6. Does your bite feel uncomfortable or unusual?	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Have you had a recent injury to your head, neck, or jaw?	☐	☐
9. Have you previously been treated for a jaw joint problem?	☐	☐

If so, when? _____

Name_____ Date_____

(Over)

EPWORTH SLEEPINESS SCALE

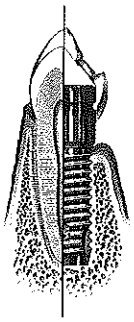
In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	
Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theatre)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 6 or greater indicates the possibility of a sleep breathing disorder

(Over)



STUART ROSS, D.M.D.
MARTIN C. NAGER, D.M.D.
BRENDA R. PIERCE, D.D.S.

Periodontics
TMJ Pain Dysfunction Syndrome
Dental Implants

OFFICE FINANCIAL POLICY

We understand that finances are a concern and make every effort to see that patients are able to have the periodontal treatment they need. Several convenient payment options are available.

PATIENTS WITHOUT INSURANCE

We accept Cash, Check, MasterCard, Visa and Discover Card for your payments at the time of your appointment. "Care Credit" is also available for interest-free financing that allows payments over six months. Please ask our Front Desk staff about "Care Credit" payment options.

PATIENTS WITH INSURANCE

Our office is pleased to submit any insurance claims when provided with the appropriate insurance information. While the patient is ultimately responsible for services rendered in the office, for those insurance companies that send their payments directly to the patient, you have the option of signing that payment over to us along with your co-payment, or keeping the payment and paying the total fee at the time of service. Some insurance companies send their reimbursement directly to our office. In those cases, patients only need to pay their co-payment at the time of service. "Care Credit" is also available for interest-free financing that allows payments over six months. Please ask our Front Desk staff about "Care Credit" payment options.

APPOINTMENT POLICY

Appointments times are specifically reserved for you. Should you need to change your appointment, we require 24 hours notice to avoid a broken appointment fee of $50.00. A surgical appointment requires 48 hours notice to reschedule to avoid a broken appointment fee.

YOUR GUMS, TEETH AND OVERALL HEALTH ARE IMPORTANT. OUR PRACTICE IS WORKING HARD TO MAKE SURE YOUR RECOMMENDED TREATMENT IS FINANCIALLY POSSIBLE.

67 Jefferson Boulevard • Warwick, Rhode Island 02888 • 401-781-2742
118 Point Judith Road • Narragansett, Rhode Island 02882 • 401-783-8464