WELCOME TO OUR PRACTICE

SAVANNAH DENTAL SPECIALTIES

LOCATION
We look forward to seeing you in our office per your scheduled initial appointment.
5102 Paulsen Street, Bldg. 7, Savannah, Georgia 31405

*Due to traffic volume in the area, it is advisable to allow an extra 30 minutes for prompt arrival.

APPOINTMENTS
Please arrive 15 minutes early to your first scheduled appointment so you may register. Late arrivals may have to be rescheduled. Your first appointment takes between 60-90 minutes. It is imperative that present timely. If you are unable to make your appointment, please call our office (912-655-8855) at least 24 hours in advance to reschedule. If you do not present to your scheduled appointment, we may not be able to reschedule your appointment for quite some time.

REGISTRATION
Please give all records and forms to the front desk staff – they will help you register in our office.

PREVIOUS RECORDS
If available, please bring to your initial appointment any x-rays or medical/dental records relating to the symptoms that you are seeking treatment for, taken within the past 6 months.

FINANCES & PAYMENTS
It is our office policy that fees are paid at the time services are rendered. TMJ treatment and oral appliance treatment for obstructive sleep apnea are normally covered under medical, not dental insurance. However, this may vary amongst employers and insurance companies. We will gladly assist you with insurance claims to expedite reimbursement. Accident and worker's compensation cases may have different arrangements.

THANK YOU. WE LOOK FORWARD TO SEEING YOU AT YOUR SCHEDULED APPOINTMENT.

SAVANNAH DENTAL SPECIALTIES

WELCOME TO OUR PRACTICE

Thank you for giving us an opportunity to help you feel better.

We only treat patients suffering from TMJ disorders, facial pain, and sleep apnea with the use of sleep appliances. The approach that we use represents the end result of many years of practice and research and has helped thousands of patients. Our staff is well trained and eager to help you – please read below to find out more about our diagnosis and treatment process.

EVALUATION PROCESS

Your first visit will be for the purpose of evaluating your problem on a comprehensive basis. This will involve a review of your health history, clinical examination, x-rays, psychometric screening, and other diagnostic records. After the evaluation process is completed, your case will be discussed with you and a management program will be formulated and reviewed with you. On occasion, additional x-rays or consultations may be necessary.

TREATMENT

Your individualized management program may involve a wide variety of modern techniques. The total length and frequency of visits also varies with the needs of each patient. You may be seen as often as once a week or as little as once or twice a month.

YOUR ROLE IN TREATMENT

Patients who come to our clinic may have a complicated and long-standing problem. In order to make your treatment at the clinic most effective, we request the following:

1. Please feel free to ask questions and seek information.
2. Please keep an open mind about the management program recommended for you.
3. Please take the responsibility to become an active participant in your management.

Make the time and commitment to follow through with the entire program offered at the clinic.

COMPLETION OF TREATMENT

When you have received maximum benefit from the active phase of your treatment, you will be placed on a maintenance program. This usually consists of a series of follow up visits at periodic intervals to monitor your continued progress. If everything is satisfactory, your treatment at the clinic ends. If any additional outside services are needed, our staff at the clinic will assist you in making the necessary referrals.

We look forward to seeing you at your scheduled appointment.

IN ORDER TO DIAGNOSE AND TREAT YOU BETTER, PLEASE TAKE YOUR TIME AND COMPLETE THE ENCLOSED QUESTIONNAIRE CAREFULLY AND ACCURATELY PRIOR TO YOUR APPOINTMENT.

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

The information you provide in this packet is vital and will assist the doctor during the review of your symptoms. Please respond to all questions. Questions contained within are confidential and will become a part of your healthcare record. Some questions are intended for governmental/statistical purposes only.

Date: _____

PATIENT INFORMATION

Name: _____ **Sex**: F ◯ M ◯
Last First Middle Initial

_____
Home Address City State Zip Code

_____/_____/_____ _____ _____ _____ _____
Date of Birth Height Weight Neck Size Email Address

Marital Status: Married ◯ Single ◯ Separated ◯ Divorced ◯ Widowed ◯ # of Children ____

Ethnicity: Non-Hispanic ◯ Hispanic/Latino ◯

Race: White ◯ Black ◯ Hispanic ◯ American Indian/Alaska Native ◯ Asian ◯
Native Hawaiian/Pacific Islander ◯ Other ◯ _____

Language: English ◯ Spanish ◯ French ◯ Arabic ◯ Chinese ◯ Sign Language ◯

Education: None ◯ Grade 1-8 ◯ High School Incomplete ◯ High School Completed ◯
College ◯ Post Graduate ◯ Professional Training ◯ Other ◯ _____

Employment: Full Time ◯ Part Time ◯ Retired ◯ Disabled ◯ Unemployed ◯ Military ◯
Student ◯ Homemaker ◯

Patient Occupation: _____ Business Name: _____
Business Phone #: _____ Address: _____

PATIENT TELEPHONE NUMBERS

Primary Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯
Alternate Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯
Alternate Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯
Mobile Carrier (for texting): AT&T ◯ Sprint ◯ Verizon ◯ Other ◯ _____

CONTACT & DISCLOSURE INFORMATION

Please provide contact name in case of an Emergency:

_____ ◯ YES ◯ NO

Name of Individual | Relationship to Patient | Primary Phone # | Leave a Message

Name of individuals to whom information about you may be disclosed:

1. _____ ◯ YES ◯ NO

Name of Individual | Relationship to Patient | Primary Phone # | Leave a Message

2. _____ ◯ YES ◯ NO

Name of Individual | Relationship to Patient | Primary Phone # | Leave a Message

If patient is a minor, please provide name of parent/guardian who is responsible for bringing the patient for treatment: _____

Parent/Guardian Name | Relationship to Patient | Primary Phone #

_____

Street Address | City | State | Zip

TREATMENT FINANCIAL RESPONSIBILITY

Person responsible for payment of this account: Self ◯ Other Individual ◯ - Please Complete Below:

_____

Responsible Individual's Name | Relationship to Patient | Date of Birth

_____

Home Address (If different than patient's) | City | State | Zip

_____

Primary Phone # | Alternate Phone # | May we leave a message? Yes ◯ No ◯

PRIMARY / MEDICAL INFORMATION

_____

Primary Insurance Company | Subscriber ID | Group # | Insurance Company Phone #

_____

Subscriber's Last Name | First Name | Relationship to Patient | Date of Birth

HEALTHCARE PROVIDER INFORMATION

Name of referring provider: _____ Phone #: _____

Family Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Other Provider: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Do you authorize us to send your treatment information? Yes ◯ No ◯

ALLERGIES

*Please indicate any known allergies & select severity of the reaction

□ Aspirin Mild Moderate Severe Reaction: _____
□ Codeine Mild Moderate Severe Reaction: _____
□ Iodine Mild Moderate Severe Reaction: _____
□ Latex Mild Moderate Severe Reaction: _____
□ Melatonin Mild Moderate Severe Reaction: _____
□ Metal Mild Moderate Severe Reaction: _____
□ Peanut Mild Moderate Severe Reaction: _____
□ Penicillin Mild Moderate Severe Reaction: _____
□ Plastic Mild Moderate Severe Reaction: _____
□ Sedatives Mild Moderate Severe Reaction: _____
□ Sleeping Pills Mild Moderate Severe Reaction: _____

□ Please list any other known allergies
□ _____ Mild Moderate Severe Reaction: _____
□ _____ Mild Moderate Severe Reaction: _____
□ _____ Mild Moderate Severe Reaction: _____

□ No known allergies

FAMILY HISTORY

*When selecting a condition, please indicate family relationship to you.

□ Bleeding disorder _____
□ Blood clotting disorder _____
□ Cancer _____
□ Cardiac disorder _____
□ Diabetes _____
□ Heart disease _____
□ High blood pressure _____
□ Obesity _____
□ Obstructive sleep apnea _____
□ Sleep disorder _____
□ Snoring _____
□ Stroke _____
□ Thyroid disorder _____
□ Temporomandibular disorders _____

HABITS

*Please check applicable area(s) below:

Tobacco Use	None □	Rarely □	Moderate □	Daily □
Alcoholic Beverages	None □	Rarely □	Moderate □	Daily □
Recreational Drugs	None □	Rarely □	Moderate □	Daily □
Caffeine Use	None □	Less than 3 cups/day □	3-6 cups/day □	More than 6 cups/day □
Exercise	None □	Rarely □	Moderate □	Regular □
Eating Habits	Well □	Regular □	Poor □	
Smoking Status	Current □	Former □		

MEDICAL HISTORY

*Please check applicable condition(s) you have or have had in the past:

Aids	□ Current	□ Past
Anemia	□ Current	□ Past
Asthma	□ Current	□ Past
High Blood Pressure	□ Current	□ Past
Low Blood Pressure	□ Current	□ Past
Cancer	□ Current	□ Past
Degenerative Arthritis	□ Current	□ Past
Diabetes	□ Current	□ Past
Emphysema	□ Current	□ Past
COPD	□ Current	□ Past
Epilepsy/Seizures	□ Current	□ Past
Gallbladder Disease	□ Current	□ Past
Glaucoma	□ Current	□ Past
Headaches (Frequent)	□ Current	□ Past
Heart Disease	□ Current	□ Past
Hepatitis Type A	□ Current	□ Past
Hepatitis Type B	□ Current	□ Past
Hepatitis Type C	□ Current	□ Past
HIV Positive	□ Current	□ Past
Insomnia	□ Current	□ Past
Kidney Disease	□ Current	□ Past
Liver Disease	□ Current	□ Past
Mental Illness	□ Current	□ Past
Migraine Headaches	□ Current	□ Past
Muscular Dystrophy	□ Current	□ Past
Narcolepsy	□ Current	□ Past
Osteoporosis	□ Current	□ Past
Pneumonia	□ Current	□ Past
Prostate Problems	□ Current	□ Past
Psychiatric Disorder	□ Current	□ Past
Restless Leg Syndrome	□ Current	□ Past
Rheumatoid Arthritis	□ Current	□ Past
Sinus Problems	□ Current	□ Past
Sleep Apnea	□ Current	□ Past
Sleep Walking	□ Current	□ Past
Stroke	□ Current	□ Past
Thyroid Disease	□ Current	□ Past
Tuberculosis	□ Current	□ Past

SOCIAL HISTORY

□ Family stress
□ Financial distress
□ Single □ Married □ Divorced □ Widowed
□ Children □ No children
Do you live alone? □ Yes □ No

□ Employed Occupation: _____
□ Unemployed
□ Retired
Diet □ Healthy □ Normal □ Restricted

SURGICAL HISTORY

□ Adenoidectomy
□ Appendectomy
□ Cholecystectomy
□ Coronary Artery Bypass Graft
□ Hernia Repair
□ Jaw Joint
□ Orthognathic
□ Prior Orthodontic Treatment
□ Sinus Surgery
□ Spinal Surgery, Cervical
□ Spinal Surgery, Lumbar
□ Temporomandibular Joint
□ Tonsillectomy
□ Uvulopalatopharyngoplasty – UPPP
□ Additional Surgeries: _____
□ _____
□ _____

CURRENT MEDICATIONS

* If you have a list, a paper copy would be sufficient.

□ Name of medication	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT CHIEF COMPLAINT

AREA OF PAIN	LOCATION	SEVERITY	DURATION	FREQUENCY
Frontal Head Pain (Forehead Area)	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant
Parietal (Top of Head)	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant
Occipital (Back of Head)	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant
Temporal (Temples)	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant
Ear Pain	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant
Facial Pain	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant
Jaw Pain	□ Right □ Left □ Both	□ Mild □ Moderate □ Severe	□ Minutes □ Hours □ Days	□ Occasional □ Frequent □ Constant

JAW JOINT SYMPTOMS

Jaw locks closed	□ Right	□ Left	□ Both
Jaw locks open	□ Right	□ Left	□ Both
Jaw joint sounds when opening	□ Right	□ Left	□ Both
Jaw joint sounds when chewing	□ Right	□ Left	□ Both
Jaw joint sounds while at rest	□ Right	□ Left	□ Both

Do you experience any associated symptoms? □ Yes □ No

OTHER RELATED SYMPTOMS

Limited neck movement	□ Right	□ Left	□ Both
Neck pain	□ Right	□ Left	□ Both
Ear buzzing	□ Right	□ Left	□ Both
Ear congestion	□ Right	□ Left	□ Both
Hearing loss	□ Right	□ Left	□ Both
Ear stuffiness/itchiness	□ Right	□ Left	□ Both

Are your symptoms injury related? □ Yes □ No

If yes, please explain: _____

Have you had an accident at work or while driving due to sleepiness? □ Yes □ No

How often do you fall asleep while driving? □ Never □ Rarely □ 1-2 times per month

□ More than 2 times per month

On average, how long does it take you to fall asleep at night? _____

Approximately, how many hours do you spend in bed? _____ How many hours do you sleep? _____

Have your muscles every felt paralyzed upon waking? □ Yes (If yes, how often?) _____ □ No

How often do sleep problems interfere with functioning? □ Always □ Often □ Rarely □ Never

SLEEP HISTORY

Have you previously been diagnosed or treated for a sleep disorder condition? □ Yes □ No

Have you ever had a sleep study? □ Yes □ No

Snoring present □ Yes □ No

Difficulty falling asleep at night	□ Yes	□ No
Difficulty staying asleep at night	□ Yes	□ No
Unusual behavior during sleep	□ Yes	□ No
Tired/sleepy during the day	□ Yes	□ No
Gasping/choking/pauses in breathing while asleep	□ Yes	□ No
Wakes with headache	□ Yes	□ No
Have you had other therapies for breathing disorders?	□ Yes	□ No
Intolerant of CPAP machine	□ Yes	□ No

CPAP INTOLERANCE

*If you have attempted treatment with a CPAP device, but could not tolerate it, list reasons below:

□ Latex allergy
□ Unconscious need to remove CPAP at night
□ Claustrophobic association
□ CPAP does not seem to be effective
□ CPAP restricted movements during sleep
□ Discomfort caused by the straps/headgear
□ Disturbed sleep caused by presence of device
□ Unable to get the mask to fit properly
□ Mask leaks
□ Noise from device disturbing my / partner's sleep
□ Pressure on the upper lip causing tooth issues
□ Other: _____

EPWORTH SLEEPINESS SCALE

*Indicate below how likely you are to doze off (or fall asleep) in the following situations.

SITUATION	NEVER	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
As a passenger in a car for 1 hour without a break	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and reading	0	1	2	3
Sitting and talking	0	1	2	3
Sitting inactive in a public place	0	1	2	3
_ tting quietly after lunch with no alcohol	0	1	2	3
Watching television	0	1	2	3

Total: _____

REVIEW OF SYSTEMS

*Check applicable condition(s) within the last 6 months and indicate controlled/uncontrolled & severity.

GENERAL

Good Health Lately □ Yes □ No
Fatigue □ Yes □ No □ Controlled □ Uncontrolled □Mild □ Moderate □ Severe
Fever □ Yes □ No □ Controlled □ Uncontrolled □Mild □ Moderate □ Severe
Injury to the face □ Right side □ Left side □ Both sides
Injury to the neck □ Right side □ Left side □ Both sides
Injury to the mouth □ Right side □ Left side □ Both sides
Injury to the teeth □ Right side □ Left side □ Both sides
Loss of sleep □ Yes □ No □ Controlled □ Uncontrolled □Mild □ Moderate □ Severe
Radiation treatment □ Yes □ No
Unexplained weight gain □ Yes □ No □ Controlled □ Uncontrolled □Mild □ Moderate □ Severe
Unexplained weight loss □ Yes □ No □ Controlled □ Uncontrolled □Mild □ Moderate □ Severe
Whiplash Injuries □ Yes □ No □ Controlled □ Uncontrolled □Mild □ Moderate □ Severe
Eye disease □ Right side □ Left side □ Both sides
Eye injury □ Right side □ Left side □ Both sides
Eye twitching □ Right side □ Left side □ Both sides

REVIEW OF SYSTEMS CONTINUED..

EAR/NOSE/MOUTH/THROAT

Bleeding gums	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Burning mouth	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Difficulty swallowing	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Dry mouth	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Ear drainage	□ Right side		□ Left side	□ Both sides			
Ear pain	□ Right side		□ Left side	□ Both sides			
Loss of hearing	□ Right side		□ Left side	□ Both sides			
Nose bleeds	□ Right side		□ Left side	□ Both sides			
Ringing in ear(s)	□ Right side		□ Left side	□ Both sides			
Sinus problems	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Sore throat	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Swollen glands	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

RESPIRATORY

Shortness of breath	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Chest pain	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Frequent cough	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

CARDIOVASCULAR

High blood pressure	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Low blood pressure	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Heart problems	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Irregular heart beat	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Swelling of feet/hands	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

GASTROINTESTINAL

Excessive thirst	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Loss of appetite	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Nausea	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Peptic ulcer	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Stomach pain	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Vomiting	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

MUSCULOSKELETAL

Back pain	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Facial muscle pain	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Jaw joint pain	□ Right side		□ Left side	□ Both sides			
Jaw joint stiffness	□ Right side		□ Left side	□ Both sides			
Jaw joint swelling	□ Right side		□ Left side	□ Both sides			
Neck pain	□ Right side		□ Left side	□ Both sides			
Weakness of face muscles	□ Right side		□ Left side	□ Both sides			
Weakness of jaw joints	□ Right side		□ Left side	□ Both sides			

NEUROLOGICAL

Confusion	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Convulsions	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Facial numbness	□ Right side		□ Left side	□ Both sides			

Chronic headaches	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Recurring headaches	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Lightheadedness	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Dizziness	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Numbness	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Paralysis	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Seizures	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Tingling sensations	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Tremors	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Memory Loss	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

ENDOCRINE

Hormone problems	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Thyroid disease	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

PSYCHIATRIC

Depression	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Forgetfulness	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Nervousness	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
Anxiety	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe
PTSD	□ Yes	□ No	□ Controlled	□ Uncontrolled	□Mild	□ Moderate	□ Severe

I, the patient attest to the best of my knowledge, all the above information is correct. I understand that I must provide at least a 24 business-hour cancelation notice. Otherwise, I will be charged a $50 cancelation fee. I understand that I am responsible for all charges incurred for my treatment or my child's treatment regardless of insurance coverage. As a courtesy, my appropriate insurance carrier may be billed for the rendered services. I hereby authorize the release of pertinent health information to the insurance company, or for legal documentation and/or to process claims. I hereby authorize my insurance benefits to be paid directly to Dr. Douglas Smith, otherwise payable to me, realizing that I am responsible to pay for my treatment, and for the non-covered services. I understand that I am responsible for charges/lab fees incurred for the appliance/mouth piece should I fail to present for the appliance insertion appointment. Charges not paid within 45 days will have a service/handing charge of $10 per month added to the past due balance on each monthly statement thereafter. If payment is not submitted, I, the undersigned also agree to pay any reasonable attorney fees and costs which are incurred by Doug Smith DDS Orthodontics LLC in collecting payment for services rendered.

I authorize the release of a full report of my records compromising of examination findings, diagnosis, imaging, treatment program, progress notes, etc., to my referring/treating or mutual providers. Copies of my records or x-rays may be released to me or to another party authorized by me upon my timely request and payment of appropriate fees.

_____ _____

Patient/Parent/Guardian Signature Date

INFORMED CONSENT FORM FOR THE TREATMENT OF TMJ AND OROFACIAL PAIN

With any medical or dental treatment, the success depends to a large extent in the degree of cooperation of the patient in following the prescribed treatment plan and keeping strategically scheduled appointments. Failure to comply with instructions and cancellations could delay the treatment time and seriously affect the success of the treatment.

Imaging is an important part of the diagnostic procedure and record keeping. Therefore, obtaining or taking the necessary images prior to treatment and during treatment may be indicated.

Your treatment may involve the fabrication and maintenance of various appliances that may cover either the upper or lower teeth. In addition, supplementary care may include various physical therapy modalities (at the office or by a physical therapist), trigger point injections, exercises, LLLT laser, and various medications. Adjunctive care by other practitioners may be indicated. Since stress is commonly a contributing factor, stress management may also be indicated.

The purpose of this treatment is to relax various groups of muscles, to restore normal function as best as possible, and to provide a degree of pain relief. The treatment itself initially may include some discomfort. Not treating these conditions may cause perpetuation of symptoms with concomitant degenerative joint changes, alteration of tooth and muscle physiology and continued discomfort.

It is difficult to give guarantees or assurances of any sort as to the results that may be obtained. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, and work habits can affect the outcome and total resolution may not always be possible. Length of treatment may vary according to the complexity of your condition. If there is not an adequate initial response, further medical diagnostics may be requested. These fees will be in addition to those incurred at this office.

As with any medical and dental treatment, unusual occurrences can and do happen. These possibilities can include minor tooth movement, loosened teeth or dental restorations, sore mouth, periodontal problems, muscle spasms, ear pain, and neck pain. For example, already loose fillings or crowns maybe loosened further while taking an impression during the course of treatment.

In the event the administration of anesthetics such as injections are used, you should be aware that there may be side effects such as prolonged numbness of the area, nerve and tissue damage, hematomas, and discomfort following the procedures.

There may be certain shifts in the position of your teeth or the relationship of one jaw to another. Depending on the nature of your original problem, these alterations of tooth or jaw position may not be reversible. Thus, additional care may be necessary, for example bite adjustment, braces, bridgework, etc.

Although any of the above mentioned complications may theoretically occur, they are rare and management of these issues will be explained as necessary at the time. In the above mentioned situations, additional dentistry may have to be performed by your dentist at your expense. Dr. Smith has explained to me the nature, purpose, benefits, risks, and alternatives to treatment.

Long term wearing of splints without professional guidance can be a detrimental situation. As long as the splint is being used, observation by our office is mandatory. The fees for these dental devices are for the impressions, bite registration and outside laboratory fabrication. Thereafter, there is a charge for each office visit.

GOOD COMMUNICATION IS ESSENTIAL FOR SUCCESSFUL TREATMENT. PLEASE FEEL FREE TO DISCUSS ANY QUESTIONS OR RESERVATIONS YOU MAY HAVE REGARDING YOUR PROBLEMS FOR TREATMENT.
THIS FORM MUST BE SIGNED BEFORE TREATMENT BEGINS.

I have read the above information and understand the course of treatment as proposed. I realize that risks and limitations are involved. I do consent to treatment by Dr. Smith. Please sign and date below:

_____ _____

PATIENT/GUARDIAN DATE

Notice of Privacy Practices Acknowledgment

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

_____ _____

PATIENT/GUARDIAN DATE

X: TMD Informed Consent

SAVANNAH DENTAL SPECIALTIES

5102 Paulsen St., Bldg. 7, Savannah, GA 31405
912.655.8855 912.335.3416 f
Douglas E. Smith, DDS, D.ABDSM, D.ACSDD savannahdentalspecialties@gmail.com
Limited to the practice of Dental Sleep Medicine & Orthodontics

FINANCIAL POLICY

We participate with many insurance plans but not all. We must make it the responsibility of the member/subscriber to understand their coverage and to contact their carrier directly to verify whether their plan covers the services our practice provides.

We bill with our tax name (Doug Smith DDS Orthodontics LLC) and Dr. Douglas Smith. Some carriers acknowledge Douglas E Smith, DDS as a participating provider but may not recognize the facility as a provider of service for the treatment you have consented to. In the event that your claim is denied for this reason, you will receive a statement in the mail for the amount due to this facility.

As a courtesy, we will file a claim on your behalf. It is the policy of Savannah Dental Specialties to wait up to 60 days for a response from your carrier. In the event we have not received a response from your carrier within that 60 days, we will refer the balance not paid by the insurance carrier, including any non-covered services and balances applied to your annual deductible, to the attention of the patient/responsible party.

Co-pays, deductibles, and co-insurance payments are due and payable at each visit prior to services being performed. You will also be asked to make a payment if your account has an outstanding balance. If you are unable to pay towards your balance or do not have your co-pay amount, you will be asked to reschedule your appointment. Patient's Initials:_____

PATIENT RESPONSIBILITY

When you receive a statement from Savannah Dental Specialties, you are required to pay the balance upon receipt of the statement. If you do not agree with the balance due amount, you are responsible for calling the phone number on the statement for an explanation of the balance and determining a payment plan, if necessary.

We reserve the right to charge the patient for missed appointments or when cancellations occur with less than 24 hours notice. A statement will be sent to the patient's mailing address and payment is expected upon receipt.

If you do not have insurance coverage, payment in full is expected at the time of service or payment arrangements may be made while you are at our office. Patient's Initials:_____

I hereby agree that if my bill has to be turned over to a third-party collection agency for non-payment, that there will be a collection fee added to my bill of 30%.

_____

Responsible Party/Guarantor's Signature

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

Patient Name:_____ **Date:**_____

Patient Consent Because of HIPPA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By signing below, you permit the release of any information to or from Dr. Smith as required including a full report of examination findings, diagnosis, and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Dr. Smith may use your health care information and may disclose such information to your insurance company(ies) and their agents to obtain payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient or Guardian Signature Witness Signature

Consent for Medical Photography:

I consent for medical photographs to be made of me (or my child). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent I contact Dr. Smith's office and place my withdrawal in writing.

By signing this form below I confirm that this consent form has been explained to me, if requested, in terms which I understand.

1. I consent for photographs to be used in medical publications. I understand that the image may be seen by members of the general public, in addition to scientists that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   _____ _____

   Patient or Guardian Signature Witness Signature

2. I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publications.

   _____ _____

   Patient or Guardian Signature Witness Signature

3. I agree to use of my image for medical records ONLY:

   _____ _____

   Patient or Guardian Signature Witness Signature

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OUT OF NETWORK PROVIDER

Please be aware that you are responsible for any charges not covered by your insurance due to our physician being out of network with some insurance plans.

With insurance constantly changing and the implementation of the **Affordable Care Act (Obamacare)** there is no way our office can accommodate the phone calls required to make sure we are in network with every patient's insurance plan. We will call to get a pre-authorization on all appliances and you will know if the appliance itself has been approved before having to commit to treatment.

If you're not sure our office is participating with your plan, please call the customer service number on the back of your insurance card to verify participation.

We will file your insurance; this does not mean in any way that our office is a participating provider for your plan. Therefore, you may receive an additional bill for any balances that were unpaid by your insurance.

Patient Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

(THIS FORM DOES NOT HAVE AN EXPIRATION DATE)