



SMITH

DENTAL SPECIALTIES

WELCOME TO OUR PRACTICE

LOCATION

We look forward to seeing you in our office per your scheduled initial appointment.
5102 Paulsen Street, Bldg. 8, 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 14 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.



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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.



SMITH

DENTAL SPECIALTIES

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:

Name of Individual Relationship to Patient Primary Phone # YES NO
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

- | | | | | |
|---|------|----------|--------|-----------------|
| <input type="checkbox"/> Aspirin | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Codeine | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Iodine | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Latex | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Melatonin | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Metal | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Peanut | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Penicillin | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Plastic | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Sedatives | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> Sleeping Pills | Mild | Moderate | Severe | Reaction: _____ |

Please list any other known allergies

- | | | | | |
|--------------------------------|------|----------|--------|-----------------|
| <input type="checkbox"/> _____ | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> _____ | Mild | Moderate | Severe | Reaction: _____ |
| <input type="checkbox"/> _____ | Mild | Moderate | Severe | Reaction: _____ |

No known allergies

FAMILY HISTORY

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

- | | |
|--|-------|
| <input type="checkbox"/> Bleeding disorder | _____ |
| <input type="checkbox"/> Blood clotting disorder | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Cardiac disorder | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> Obesity | _____ |
| <input type="checkbox"/> Obstructive sleep apnea | _____ |
| <input type="checkbox"/> Sleep disorder | _____ |
| <input type="checkbox"/> Snoring | _____ |
| <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Thyroid disorder | _____ |
| <input type="checkbox"/> 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	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Kidney Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Anemia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Liver Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Asthma	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Mental Illness	<input type="checkbox"/> Current	<input type="checkbox"/> Past
High Blood Pressure	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Migraine Headaches	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Low Blood Pressure	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Muscular Dystrophy	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Cancer	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Narcolepsy	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Degenerative Arthritis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Osteoporosis	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Diabetes	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Pneumonia	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Emphysema	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Prostate Problems	<input type="checkbox"/> Current	<input type="checkbox"/> Past
COPD	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Psychiatric Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Epilepsy/Seizures	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Restless Leg Syndrome	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Gallbladder Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Rheumatoid Arthritis	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Glaucoma	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Sinus Problems	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Headaches (Frequent)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Sleep Apnea	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Heart Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Sleep Walking	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Hepatitis Type A	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Stroke	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Hepatitis Type B	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Thyroid Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Hepatitis Type C	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Tuberculosis	<input type="checkbox"/> Current	<input type="checkbox"/> Past
HIV Positive	<input type="checkbox"/> Current	<input type="checkbox"/> Past			
Insomnia	<input type="checkbox"/> Current	<input type="checkbox"/> Past			

SOCIAL HISTORY

Family stress Employed Occupation: _____
 Financial distress Unemployed
 Single Married Divorced Widowed Retired
 Children No children
Do you live alone? Yes No 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.

<input type="checkbox"/> Name of medication	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT CHIEF COMPLAINT

AREA OF PAIN	LOCATION	SEVERITY	DURATION	FREQUENCY
Frontal Head Pain (Forehead Area)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Parietal (Top of Head)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Occipital (Back of Head)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Temporal (Temples)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Ear Pain	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Facial Pain	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Jaw Pain	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Disturbed sleep caused by presence of device |
| <input type="checkbox"/> Unconscious need to remove CPAP at night | <input type="checkbox"/> Unable to get the mask to fit properly |
| <input type="checkbox"/> Claustrophobic association | <input type="checkbox"/> Mask leaks |
| <input type="checkbox"/> CPAP does not seem to be effective | <input type="checkbox"/> Noise from device disturbing my / partner's sleep |
| <input type="checkbox"/> CPAP restricted movements during sleep | <input type="checkbox"/> Pressure on the upper lip causing tooth issues |
| <input type="checkbox"/> Discomfort caused by the straps/headgear | <input type="checkbox"/> 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
Sitting 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

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/handling 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 comprising 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

INFORM 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



5102 Paulsen St., Bldg. 8, Savannah, GA 31405
912.655.8855 912.335.3416 f

Douglas E. Smith, DDS, D.ABDSM, D.ACSDD smithdentalspecialties@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 Smith 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 Smith 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/or convey directly to Doug Smith DDS Orthodontics LLC, 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 Dr. Smith for today's treatment/services and future treatment/services, 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 Dr. Smith 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 Dr. Smith 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 Dr. Smith any legal or administrative claim or cause of action arising under any group health plan, employee benefits plan, health insurance or tort feisor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Dr. Smith (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 Doug Smith DDS Orthodontics LLC 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 Doug Smith DDS Orthodontics LLC, 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 (Doug Smith DDS Orthodontics LLC) 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. Doug Smith DDS Orthodontics LLC 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