PATIENT REGISTRATION FORM

Patient Name _____ **Date** _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

Social Security Number _____ Birth Date _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Person Responsible for Account _____

Dental Insurance Group _____ Group # _____

Employee Name _____

Social Security Number _____ Birth Date _____

Emergency Contact _____

Home Phone _____ Business Phone _____ Cell Phone _____

Referred to us by _____

Reason for leaving your last dentist _____

_____

_____

Edgerton & Glenn
cosmetic & general dentistry

MEDICAL QUESTIONNAIRE

Any History of:

Heart Problems ☐ YES ☐ NO	Bronchitis ☐ YES ☐ NO	Heart Valve Problems ☐ YES ☐ NO
High Blood Pressure ☐ YES ☐ NO	Fever Blisters/Herpes ☐ YES ☐ NO	Nose Obstruction ☐ YES ☐ NO
Rheumatic Fever ☐ YES ☐ NO	Stroke ☐ YES ☐ NO	Hypoglycemia ☐ YES ☐ NO
Emotional Stress ☐ YES ☐ NO	Thyroid Problems ☐ YES ☐ NO	Hyperglycemia ☐ YES ☐ NO
Asthma ☐ YES ☐ NO	Sinus Trouble ☐ YES ☐ NO	Prostate Problems ☐ YES ☐ NO
Blood Transfusions ☐ YES ☐ NO	Kidney or Liver Disease ☐ YES ☐ NO	Lung Disease ☐ YES ☐ NO
Hepatitis ☐ YES ☐ NO	Glaucoma ☐ YES ☐ NO	Contact Lenses ☐ YES ☐ NO
Artificial Joints ☐ YES ☐ NO	Allergies ☐ YES ☐ NO	Cancer ☐ YES ☐ NO
Heart Murmur ☐ YES ☐ NO	Prolonged Bleeding ☐ YES ☐ NO	Ulcers ☐ YES ☐ NO
Cortisone or ACT II ☐ YES ☐ NO	Epilepsy/Convulsions ☐ YES ☐ NO	Emphysema ☐ YES ☐ NO
Anemia ☐ YES ☐ NO	Arthritis ☐ YES ☐ NO	Fainting or Dizzy Spells ☐ YES ☐ NO
Tested Positive for HIV ☐ YES ☐ NO	Diabetes ☐ YES ☐ NO	Epinephrine Sensitivity ☐ YES ☐ NO

Do you have, or have you had, any diseases, conditions or problems not listed?

If yes, please specify: _____

Are you being treated by a physician now or have in the last six months? ☐ YES ☐ NO

Your Physician's Name _____

Are you taking any medications? ☐ YES ☐ NO *(This includes over-the-counter drugs and prescription drugs)*

If yes, please specify: _____

Are you allergic to any medications? ☐ YES ☐ NO *If yes, please specify:* _____

Any recent serious illnesses? ☐ YES ☐ NO *If yes, please specify:* _____

For women only: Are you pregnant? ☐ YES ☐ NO If yes, what month? _____

Are you nursing? ☐ YES ☐ NO

Are you on birth control? ☐ YES ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

SIGN HERE Patient Signature _____ Date _____

Consent:

I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective healthcare provider or agency who may release such information to you. I will notify this office of any changes in my health or medication. The undersigned hereby authorizes this office to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I/We promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. All diagnostic aids and documentation are the property of this office. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another dentist. I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

SIGN HERE Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Edgerton & Glenn
cosmetic & general dentistry

DENTAL QUESTIONNAIRE

Last _____ First _____ MI _____ Nickname _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ☐ YES ☐ NO
2. Have you ever had any problems associated with previous dentistry? ☐ YES ☐ NO
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. Date of your last dental visit? _____
5. Have you ever been treated for any type of gum problems? ☐ YES ☐ NO
6. How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard
7. Are you happy with the appearance of your teeth? ☐ YES ☐ NO
   If no, what would you change? _____
8. Do you have, or have you ever had, any of the following?

Mouth Problems:

Bleeding/sore gums ☐ YES ☐ NO
Unpleasant taste/bad breath ☐ YES ☐ NO
Burning tongue/lips ☐ YES ☐ NO
Frequent blisters/lips/mouth ☐ YES ☐ NO
Swelling/lumps in mouth ☐ YES ☐ NO
Ortho treatment (braces) ☐ YES ☐ NO
Biting cheeks/lips ☐ YES ☐ NO
Clicking/popping jaw ☐ YES ☐ NO
Difficulty opening or closing jaw ☐ YES ☐ NO
Headaches ☐ YES ☐ NO

Teeth Problems:

Loose teeth ☐ YES ☐ NO
Sensitive to hot ☐ YES ☐ NO
Sensitive to cold ☐ YES ☐ NO
Sensitive to sweets ☐ YES ☐ NO
Sensitive to biting ☐ YES ☐ NO
Food stuck in teeth ☐ YES ☐ NO
Clenching/grinding ☐ YES ☐ NO
If so, when _____
Shifting in bite ☐ YES ☐ NO
Change in bite ☐ YES ☐ NO

9. Do you use the following?

Brush ☐ YES ☐ NO
Fluoride Rinse ☐ YES ☐ NO
Dental Floss ☐ YES ☐ NO
Other _____

10. How would you rate your dental health? ☐ Excellent ☐ Good ☐ Poor
11. Any concerns or questions you have? _____

_____

These are things that are important to me about my dental health:

_____

_____

_____

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Screening for Obstructive Sleep Apnea

Name Date

Obstructive Sleep Apnea (OSA) is a common, but serious medical condition that can affect your sleep, health and quality of life. If left untreated, OSA sufferers are at higher risk of:

- Excessive daytime sleepiness
- High blood pressure
- Heart attack
- Stroke
- Diabetes
- Decreased sex drive
- Driving and work-related accidents

OSA can be dangerous. It's important to treat OSA if you have it.

Answer the following questions to find out if you are at risk. Your health is important to us!

S	**Snoring**	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	**YES NO**
T	**Tired**	Do you often feel tired, fatigued, or sleepy during the day?	**YES NO**
O	**Observed**	Has anyone observed you stop breathing or gasp during sleep?	**YES NO**
P	**Blood Pressure**	Have you had, or are you currently being treated for, high blood pressure?	**YES NO**
B	**BMI**	Is your BMI (body mass index) greater than 35?	**YES NO**
A	**Age**	Are you over 50 years old?	**YES NO**
N	**Neck Circumference**	Is your neck size greater than 17" (male) 16" (female)?	**YES NO**
G	**Gender**	Are you male?	**YES NO**

1 (877) 341-8814
customersuccess@zephyrsleep.com

zephyrsleep.com

ZEPHYR Sleep Technologies

Screening for Obstructive Sleep Apnea

Name Date

Sleepiness score

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have aected you.

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	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (e.g. a theatre or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

1 (877) 341-8814
customersuccess@zephyrsleep.com

ZEPHYR Sleep Technologies

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Consent for Release of Dental Records

Edgerton and Glenn, PA
1426 Commonwealth Drive Suite A
Wilmington, NC 28403
910-256-9230
910-256-9004 (Fax)

I, _____, do hereby consent to authorize

Dr. _____to disclose to Dr._____

Information in my dental records including current and previous records from other practices and practitioners, hospitals, and /or clinics which are part of my dental records.

My date of birth is_____
This information is strictly for purposes of identification.

_____ _____
Patient Signature **Date**

If additional consent is necessary from a person to give consent, other than the patient (such as parent, guardian, etc.)

_____
Signature

_____
Relationship to the Patient

PLEASE EMAIL RECORDS TO:

marsha@edgertonandglenn.com

jennifer@edgertonandglenn.com

Authorization for Release of Information - Compound Release

Name of Patient _____ Date of Birth _____

DR.'S STEPHEN EDGERTON & TAYLOR GLENN is authorized to release protected health information about the above name patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment reminder
☐ Other person(s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication (provide email address) _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Appointment reminders
☐ Text communication (provide number) _____ *For text communications to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other _____
☐ For email and/or text communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject in reinclosure by the recipient and may not longer be protected by Federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

• Description of Personal Representative's Authority (attach necessary documentation)

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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 took 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, evaluation of 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 or 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 or 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 or 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients 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.) We may also remind you of your need to pre-medicate if applicable.

PATIENT RIGHTS

Access: You have the right to look at or get 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 practically do so. You must make a request in writing to obtain access to your health 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 $1.00 for each page, $25 per hour for staff time to locate and copy your health information, and postage if you want the 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 by using the information 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 for a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that 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.

QUESTIONS & COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____