Longmont Prosthodontics
RYAN LEWIS, DMD, MSD

1325 Hover St #103
Longmont, CO 80501
(303) 834-5723

Registration Form

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____

Home _____ Office _____ Mobile _____

E-mail _____

Preferred method of communication? _____

Gender: ☐ Male ☐ Female ☐ _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Whom may we thank for your referral? _____

Date of Birth ☐☐☐☐ Patient SSN ☐☐☐ - ☐☐ - ☐☐☐☐

Emergency Contact _____

Relationship to Patient _____ Phone _____

Responsible Party

Person Financially Responsible for Account _____

If different from patient, please provide the following information

Name _____

Address _____

City _____ State _____ Zip _____

Home _____ Office _____ Mobile _____

E-mail _____

Preferred method of communication? _____

Relationship to Patient? _____

Date of Birth ☐☐☐☐ Patient SSN ☐☐☐ - ☐☐ - ☐☐☐☐

_____ _____
Signature of Responsible Party Today's Date

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FINANCIAL AGREEMENT

It is our goal for our patients to understand their needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all our patients. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Please review the following policies and procedures:

Payment Policies: In order to provide the highest level of service for our patients, we are a fee for service provider, meaning that all payment is due at the time of service. Due to the contractual limitations placed by dental insurance companies, we do not participate with any insurance, however we are happy to provide you the necessary information to be submitted for reimbursement from your dental plan.

For prosthetic services we require half of the treatment plan amount at the start of treatment and the balance to be paid over the remaining appointments. We require full payment prior to the completion of your case. Extensive treatment may require special payment arrangements, and we will work alongside you to establish arrangements for you at the treatment planning conference.

Payment Options: We accept cash, personal checks, money orders, debit cards, Visa, Mastercard, and Discover as well as personal financing through Care Credit or Compassionate Financing.

If there is a balance and the charges have been in the account for over 90 days, you will pay Longmont Prosthodontics 18% finance charge per month on the unpaid balance until paid in full.

You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/or attorney fees).

Fees will be applied for any check that is returned by the bank.

MINOR PATIENTS: In the case of divorced or separated parents, it is YOUR responsibility to have financial arrangements made according to the divorce decree BEFORE treatment begins.

BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of up to $50 (fee based on appointment length and/or number of appointments missed). Missed or broken appointments prevent others from receiving the dental care they deserve.

We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

If you have any questions, please do not hesitate to ask. We are here to help you get the smile you want.

I have read and understand this document in its entirety; outlining the office and financial policies of Longmont Prosthodontics and agree to these terms.

_____

Signature of patient or parent/guardian

_____

Date

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WAIVER AND CONSENT

I, _____ the undersigned, do hereby authorize and consent to the use of certain photographs/x-rays of me taken by _____ _____. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in the form of prints, slides or film for use in connection with articles and lectures dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.

Polaroid photography taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crowns, bridges or dentures and are a part of your permanent dental record.

Patient's Signatures and/or Guardian _____

Patient's Address_____

_____

Date_____

Please initial one of the following:

_____ **I do not** consent to the use of slides or photographs for use in dental education or publications.

_____ **I do** consent to the use of slides or photographs for use in dental education or publications.

_____ **I do** consent to the use of slide or photographs EXCEPT full face or identifying views.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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We Welcome All Patients

Our goal is to help you take care of your teeth, smile and mouth at a level that is right for you.

We believe that it is your choice on the level of care that you want in our practice. We will help you thoroughly understand your dental choices so you can make the best decision possible. Your first choice is how you would like us to work with you. Before we begin your appointment, please consider the following guidelines for care so that we can best meet your goals:

☐ **LEVEL 1: URGENT CARE**
Patients at this level choose treatment only when they experience a crisis such as pain, swelling or bleeding that requires immediate treatment. Urgent care patients are generally not focused on taking steps to ensure future urgencies do not occur. They come in when they know they have a major problem to deal with and the condition has developed to a point of urgency in order to control pain or save the tooth.

☐ **LEVEL 2: REMEDIAL CARE**
Patients at this level choose treatment for obvious problems such as broken or cracked teeth, cavities, sensitivity, discomfort or concerns that are creating issues in the mouth right now. Remedial care patients are usually not focused on taking steps to prevent new concerns or improve their health over time. They only want to deal with concerns that have already developed into conditions that require treatment to remove existing disease or repair the teeth back to the most basic level of health.

☐ **LEVEL 3: PROACTIVE CARE**
Patients at this level seek treatment for existing concerns just like remedial care patients, but they are also concerned about conditions that may create problems in the near future. These patients generally want to maintain the health of each tooth at a basic level so they also do what they can to prevent new concerns from developing. When treatment is recommended, proactive care patients usually prioritize their treatment to manage their costs but still take care of things soon enough so that known concerns are less likely to develop into major problems.

☐ **LEVEL 4: COMPLETE DENTISTRY**
Complete dentistry patients are concerned about the current conditions in their mouth, the causes of dental disease and their long-term health. They want to know their full treatment options so they can become and remain as healthy as they can be, thereby minimizing their long-term dental costs. These patients often choose a step-by-step master plan focused on restoring their health combined with prevention and regular care to achieve steady long-term dental health and an improved appearance to their smile over time.

☐ **LEVEL 5: OPTIMAL DENTISTRY**
Just like complete dentistry patients, patients at this level are focused on long-term dental health and disease prevention, but they also want their teeth and smile to look great. Patients at this level are interested in treatment options to correct all dental concerns for lifelong optimal function and appearance. For some of these patients, enhancing their appearance with a beautiful new smile is very important.

During your initial appointment we will review these levels of care to help you choose how we should start. It is not uncommon for patients to begin at one level and progress to higher levels when they are ready. We're here to help you discover what is right for you so your teeth, smile and mouth remain as healthy as they can be for life based on your goals.

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Dental History

Name _____ Date of Birth ☐☐☐☐ Age ☐☐

Dentist _____ Office Phone _____

Specialty Dentist _____ Office Phone _____

Why are you seeking dental treatment? _____

_____

_____

Have you ever had any serious trouble associated with previous dental treatment? _____

_____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Date of your last dental visit? _____ Date of your last dental cleaning? _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

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

	YES	NO		YES	NO
Bleeding, sore gums	☐	☐	Loose Teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to cold	☐	☐
Burning tongue/lips	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Orthodontics (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching/grinding	☐	☐
Clicking/popping jaw	☐	☐	Shifting of Teeth	☐	☐
Difficulty opening or closing jaw	☐	☐	Change in bite	☐	☐

Do you use any of the following?

	YES	NO	
Tobacco, in any form?	☐	☐	If so, how much? _____
Alcohol?	☐	☐	If so, how much? _____
Recreational drugs?	☐	☐	If so, how much? _____

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Medical History

Primary Care Physician _____ Office Phone _____

Specialty Doctor _____ Office Phone _____

Are you currently under the care of a physician? ☐ Yes ☐ No

If so, what is the condition being treated? _____

_____

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No

If yes, please explain _____

_____

Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? ☐ Yes ☐ No

Are you pregnant or planning to become pregnant? ☐ Yes ☐ No

Are you allergic to or have you had any reaction to the following?

	YES	NO		YES	NO
Bleeding, sore gums	☐	☐	Loose Teeth	☐	☐
Local anesthetics (Novocaine)	☐	☐	Aspirin or codeine	☐	☐
Barbiturates/sedatives	☐	☐	Sulfa drugs	☐	☐
Antibiotics	☐	☐	Other _____		

Are you currently taking any of the following?

Antibiotics	☐	☐	Tranquilizers	☐	☐
Sulfa Drugs	☐	☐	Herbal supplements	☐	☐
Blood pressure medication	☐	☐	nsulin/diabetes medication	☐	☐
Thyroid medication	☐	☐	Recreational drugs	☐	☐
Cortisone/steroids	☐	☐	Heart medication	☐	☐
Antihistamines (allergy, cold med)	☐	☐	Nitroglycerin	☐	☐

Please list all medications you are currently taking — Reason for use

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

*** If you are taking more than six medications, please provide use with a complete list separately.*

Please list all vitamins/supplements you are currently taking:

_____

_____

_____

_____

Continue on next page

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Medical History (continued)

	YES	NO
General		
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night Sweats	☐	☐
Persistent Fever	☐	☐
Skin		
Eruptions (rash, hives)	☐	☐
Changes in skin color	☐	☐
Eyes		
Visual change	☐	☐
Glaucoma	☐	☐
Vision loss	☐	☐
Nose		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
Throat		
Soreness/hoarseness	☐	☐
Nervous System		
Stroke	☐	☐
Headaches/migraines	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatmen	☐	☐
Respiratory		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum (phlegm) production	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing lying down	☐	☐
Endocrine		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other _____		

	YES	NO
Heart/Blood Vessels		
Rheumatic fever	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heard valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other _____		
Bone/Muscles		
Arthritis/rheumatism	☐	☐
Artificial joint/limbs	☐	☐
Digestive System		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
Urinary		
Kidney disease	☐	☐
Frequent urination (night)	☐	☐
Burning urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
Blood		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
Others		
Eating disorder	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors/growths	☐	☐
Cancer	☐	☐
HIV/AIDS	☐	☐

Signature _____ Date _____

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Screening for Airway Issues

Sleep Screening Questionnaires

Dr. Lewis likes to perform sleep/airway screenings on new patients. It is now known that a lot of dental issues that are affecting most people are being related to poor quality sleep and restrictive airway issues. Please answer the questions below to help us assess for possible airway issues, such as sleep apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Such airway issues can increase your risk for many health conditions. It can also increase your risk for healing and breathing problems after surgery.

Name _____ Date of Birth _____/_____/_____ Age _____

Height _____ Weight _____ BMI _____

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

EES: Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

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

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Screening for Airway Issues

STOP - BANG

The purpose of the STOP-BANG questionnaire is to determine “high” or “low” risk for sleep apnea.

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

Analyze Your STOP - BANG Score

Your **TOTAL** number of **YES**: _____

High risk of OSA:	**Yes 5-8**
Intermediate risk of OSA:	**Yes 3-4**
Low risk of OSA:	**Yes 0-2**

Analyze Your ESS Score

Your **combined number** from page 1: _____

0-7:	It is unlikely that you are abnormally sleepy.
8-9:	You have an average amount of daytime sleepiness.
10-15:	You may be excessively sleepy depending on the situation.
16-24:	You are excessively sleepy and should consider seeking medical attention

References:
Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5
Chung F et al. STOP-BANG Sleep Apnea Questionnaire. Anesthesiology 2008, BJA 2012