Advanced Cosmetic Dentistry

Welcome

"Dedicated Professionals Fulfilling Dental Cosmetic Dreams"

Name _____ Email _____ Birthdate _____

Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell# _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

If you carry Dental Insurance please provide your Insurance Card and Social Security Number _____

Notify in case of emergency _____ Phone# _____ Relationship _____

MEDICAL HISTORY

Have you ever had any of the following? (Circle all that apply)

Heart Murmur	Epilepsy	Rheumatic Fever	High/Low Blood Pressure	Hepatitis
Diabetes	Cancer/Chemotherapy	Sinus Problems	Asthma/Arthritis	Ulcers
Artificial Valves/Joints	Congenital Heart Defect	Radiation Treatment	Blood Transfusion	Anemia
Difficulty Breathing	Emphysema/Glaucoma	Heart Attack/Stroke	Heart Surgery/ Pacemaker	Hemophilia
HIV/AIDS	Kidney Problems	Shingles	Mitral Valve Prolapse	Oral Herpes
Severe/ Frequent Headaches		Hospitalized For Any Reason		

Do you have any drug ALLERGIES or have you ever had an adverse reaction to any medication? _____

Current Medications_____

Physician's Name_____ Phone# _____ Date of Last Physical _____

Are you currently under the care of a physician? _____ If so, why _____

(Women) Do you suspect that you are pregnant?_____ Nursing?_____

Dental History

Do you floss daily? _____ Brush daily? _____ Do your gums ever bleed? _____
Decay Rate: Please circle. High Medium Low Periodontal (Gum) Surgery?_____ Oral Cancer?_____
Wisdom Teeth out _____ History of Orthodontics? _____When?_____# of times_____Retainers?_____
History of extensive Dental Work?_____
Bad Experience in Dental Office?_____
Do you clench?_____ Grind?_____ Wear a Mouth/Bite/Night Guard?_____
Do you snore?_____ Do you have Sleep Apnea?____ Do you wear a CPAP?_____ Have you ever had a Sleep Study?____
Are you interested in improving Athletic performance with a custom made mouth guard?_____

I understand that the above information will help Dr. Popp determine appropriate and healthy dental treatment. If there is any change in my medical status, I will inform her. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Name _____ **Date**_____

Please Circle which level describes your current Dental condition

The 5 Levels of Dental care we offer our patients

We understand that choosing a new dentist and dental health team can be a challenge, leaving you feeling somewhat uncertain. Let us welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to enhance the quality of their lives. "

In other words, we help you be to become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. There are five levels on which people may choose to be seen in our practice. Please circle the level of care you feel most appropriate for you at this time.

Level 1 URGENT CARE People in crisis or with an emergency problem such as pain swelling, or bleeding that need our immediate help are at this level. We see emergencies immediately, whenever possible.
Level 2 REMEDIAL CARE People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally people at this level expect a limited type of examination, focusing on obvious problems. They usually want to correct immediate problems with as little effort and cost as possible.
Level 3 SELF-CARE Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short range in nature. Sometime these patients phase their dentistry, completing treatment as Dr. Popp prioritizes.
Level 4 COMPLETE DENTISTRY Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion possible, as soon as possible.
Level 5 LOOK YOUR BEST People in this group are in level 4 as far as dental health is concerned, but also want to look their best at all times. They know that their smile is the first things others notice about them and want to put their best foot forward. They understand the need for a proper function for Cosmetic Dentistry.

We hope these levels of care make sense to you. It is not uncommon for people to begin at one level and progress to another over time. We are here to help you discover and decide at what level you are most comfortable. Thank you for the opportunity to serve you and provide you with the best treatment for you.

Dental History

To aid in our diagnosis and treatment of your esthetic concerns and to prepare your Personalized Dental Plan, please take a moment to answer the following questions.

Do you dislike the color of your teeth?	YES	NO
Have you whitened your teeth? If so, how?_____	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too short or too long?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Do your gums show too much when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing crowns or dental work that you consider "ugly"?	YES	NO
Are you self-conscious of your teeth and/or smile?	YES	NO
Has anyone (family member or friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a "new smile"?	YES	NO
Are you interested in knowing what your cosmetic options are?	YES	NO

TMJ issues

Please rate your current degree of comfort or discomfort as:

"1" no pain and "10" worst possible pain/discomfort

TMJ clicking/grating	____
TMJ locking/stiffness	____
Inability to open mouth	____
Mouth doesn't open straight	____
Pain when eating/chewing	____
Pain in jaw or jaw joint	____
Unstable bite	____
Headaches	____
Face pain	____
Neck pain	____
Ear pain/ stiffness	____
Ringing in ears	____
Difficulty swallowing	____
Throat pain	____
Other_____	____
Other_____	____

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OUR FINANCIAL AGREEMENT

We are very pleased that you have chosen us as your dental care provider. We are committed to your treatment being successful. We are excited to provide you with quality care in a pleasant atmosphere. Please understand that payment of your bill is considered a part of your treatment.

- **Full payment is expected at the time of service.**
- **For treatment over $2000 full payment is expected before a reservation can be made.**
- **We accept Cash, Checks, Visa, MasterCard, Discover, and American Express.**
- **A $25.00 charge will be assessed for returned checks.**
- **All accounts with balances remaining after 30 days of services rendered will be assessed a minimum late payment charge of $45.00 a month.**

Regarding Insurance
To avoid a misunderstanding regarding dental insurance, we wish our guests to know that all professional services are charged directly to the guest and that the guest is personally responsible for payment of services. We will gladly assist you in preparing necessary forms to help you obtain your maximum benefits from your insurance company. We do not render our services on the basis that insurance companies will pay all of our fees.

Regardless of what we might estimate as your dental benefits, we must stress the fact that you, the guest, are responsible for the total amount of any treatment fees. We allow 60 days for your insurance company to make a payment. After this time all inquires (follow up) on payments due become your responsibility.

Usual and Customary Rates
You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that insurance companies are for profit companies.

Minor Patients
The adult accompanying a minor is responsible for full payment. For unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized.

Thank you for understanding our Financial Agreement. Please let us know if you have questions or concerns.

I have read the Financial Agreement. I understand and agree to the Financial Agreement.

X_____ Date_____
Signature of Guest or Responsible Party

Advanced Cosmetic Dentistry

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 takes effect 04/14/2003, and will remain in effect until we replace it.

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

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or 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 practicably 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 $0.15 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

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

Restriction: You have the right to request 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND 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: **Dr. Suzanne Popp**

Telephone: **(619)435-4444** E-mail: **Smmpopp@aol.com**

Address: **1010 Eighth Street, Coronado CA 92118**

Advanced Cosmetic Dentistry
Suzanne M. Popp, D.D.S.
1010 Eighth Street
Coronado, CA 92118-2124

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Sleep Disorder Assessment

Your Dentist requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a user friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Patient Name:_____

Physician Name:_____**Phone Number:**_____

1. Have you ever been given a CPAP device?.....Yes___No___
2. If you have been given any form of CPAP, do you use it nightly.....Yes___No___
3. Are you comfortable with your CPAP and satisfied with its use.....Yes___No___

If the answer is "Yes" to all three questions, YOU ARE DONE!

If your answer is "No" to any of the above questions, please continue to Part 1.

Part 1 Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never 1 = slight 2 = moderate 3 = high Circle one of the following numbers.

1. Being a passenger in a motor vehicle for an hour or more?..... 0 1 2 3
2. Sitting and talking to someone?..... 0 1 2 3
3. Sitting and reading?..... 0 1 2 3
4. Watching TV?..... 0 1 2 3
5. Sitting inactive in a public place?..... 0 1 2 3
6. Lying down to rest in the afternoon?..... 0 1 2 3
7. Sitting quietly after lunch without alcohol?..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic?..... 0 1 2 3

Part 2

1. Have you ever been told you snore.....Yes___No___
2. Does your family have a history of premature death..... Yes___No___
3. Do you have diabetes..... Yes___No___
4. Have you ever been told you have coronary artery heart disease.. Yes___No___
5. Do you have high blood pressure..... Yes___No___
6. Have you ever experienced irregular heart rhythms..... Yes___No___

Part 3

1. Have you ever been diagnosed with sleep apnea..... Yes___No___
2. Do you awaken from sleep with chest pain or shortness of breath.... Yes___No___
3. Has anyone said you seem to stop breathing while sleeping..... Yes___No___
4. Is your neck size larger than 15" (female) 16.5 (male)..... Yes___No___
5. Have you ever had a stroke..... Yes___No___
6. Have you ever been told you have congestive heart failer.....Yes___No___
7. Do you have or did you ever have arterial fibrillation..... Yes___No___

Dentist Signature: