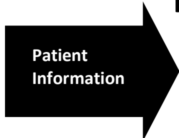
Please complete **ALL** the following confidential information:



Date: ____

Name: ____

Spouse: ____

Address: ____

City: _______________________ State: ______ Zip: ______

Home Phone: ____________________________________

Cell Phone: _____________________________________

Work Phone: ____________________________________

Occupation: _____________________________________

Email: ____

Birthday: ________________ Age: ______ Male Female

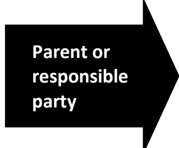
Married Single Divorced Widowed

Social Security Number: ____________________________

Referred by: ______________________________________

Emergency contact of a **DIFFERENT** address:

Name: ____



Name: ____

Spouse: ____

Address: ____

City: ______________________ State: ______ Zip: _______

Home Phone: _____________________________________

Cell Phone: ______________________________________

Email: ____

Birthday: _______________ Age: ______ Male Female

Married Single Divorced Widowed

Social Security Number: ____________________________

BOSQUE DENTAL CARE
723 E 65th St
Savannah, GA 31405
912.355.0555
bosquedentalcare.com

DENTAL INSURANCE

Insurance Company: ______________________

____

Group No.: ______________________________

Employee: _______________________________

Date of Birth: ____________________________

Employee SSN: ___________________________

Employee ID Number: _____________________

ACCOUNT INFORMATION

If the person financially responsible for the account is **not** the patient, please fill out the following information:

Name: __________________________________

Relationship to Patient: ___________________

Address: _________________________________

____

City: ____________________________________

State: ________________ Zip: ______________

YOUR SPOUSE

Name: __________________________________

Occupation: ______________________________

Employer: _______________________________

Business Phone: __________________________

HEALTH HISTORY

1. Have you been under the care of a medical doctor during the past two years? ( ) yes ( ) no
   If yes, for what?____
   Physician's Name____Phone ____________________

2. Have you taken any medications or drugs the past two years? ( ) yes ( ) no

3. Are you taking any medications, drugs or pills now? ( ) yes ( ) no
   If yes, please list____

4. Are you aware of having an allergic reaction to any medication? ( ) yes ( ) no
   If yes, please list____

5. Have you been a patient in the hospital during the past five years? ( ) yes ( ) no

6. Do you have any condition that requires you to take an antibiotic before having any dental work
   done? ( ) yes ( ) no

7. Circle any of the following which you have had or have at present:

Heart (Surgery, disease, disorder)	Chest Pain	Congenital Heart Disease
Heart Murmur	High Blood Pressure	Artificial Heart Valve
Heart Pacemaker	Rheumatic Fever	Arthritis/Rheumatism
Cortisone Medicine	Swollen Ankles	Strokes
Diet (Special/Restricted)	Artificial Joints	Kidney Trouble
Hepatitis A (Infectious) B (serum)	AIDS	Cold sores/Fever Blisters
Hemophilia	Bruise Easily	Liver Disease
Neurological Disorders	Fainting/Dizzy Spells	Psychiatric Care
Ulcers	Diabetes	Thyroid Problems
Glaucoma	Contact Lenses	Emphysema
Chronic Cough	Tuberculosis	Asthma
Hay Fever	Latex Sensitivity	Allergies/Hives
Sinus Trouble	Radiation Therapy	Chemotherapy
Tumors	Venereal Disease	HIV Positive
Blood Transfusion	Sickle Cell Disease	Yellow Jaundice
Epilepsy/Seizures	Nervous/Anxious	

8. Do you use more than two pillows to sleep? ( ) yes ( ) no

9. Have you lost or gain more than 10 pounds in the past years? ( ) yes ( ) no

10. Do you have or have you had any disease, condition, or problem not listed? ( ) yes ( ) no
    If yes, please list____

11. Women: Are you pregnant? ( ) yes, _______months ( ) no, Nursing? ( ) 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 questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature____

Date of last dental visit_____________________	How often do you have dental exams?________
Last dental cleaning _______________________	How often do you brush your teeth? _________
Last full mouth x-rays ______________________	How often do you floss? ___________________
Pervious Dentist's Name __________________	What other dental aids do you use? __________ (interplak, toothpick, etc.)
Phone _________________________________	Do you use a soft or hard tooth brush? _______
Do you have any dental problems now? ______________________________________	

Are your teeth sensitive to: Hot or Cold? Sweets? Biting or Chewing?
Have you noticed any mouth odors or bad taste? ( ) yes ( ) no
Do you frequently get cold sores or blisters? ( ) yes ( ) no
Do your gums bleed or hurt? ( ) yes ( ) no
Have your parents experienced gum disease or tooth lost? ( ) yes ( ) no
Have you noticed any loose teeth or change in your bite? ( ) yes ( ) no
Does food tend to become caught in between your teeth? ( ) yes ( ) no

Do You:
Clench or grind your teeth while awake or asleep? ( ) yes ( ) no
Bite your lips or cheeks regularly? ( ) yes ( ) no
Hold foreign objects with your teeth? (pencils, pipe, pens, nails) ( ) yes ( ) no
Have tired jaws, especially in the morning? ( ) yes ( ) no
Smoke/chew tobacco? ( ) yes ( ) no

Have you ever had:
Orthodontic Treatment? ( ) yes ( ) no
Periodontal Treatment? ( ) yes ( ) no
A serious injury to the mouth or head? ( ) yes ( ) no
Your bite adjusted? ( ) yes ( ) no
Oral Surgery? ( ) yes ( ) no
A Mouth Guard? ( ) yes ( ) no

Have you experienced:
Clicking or popping of the jaw? ( ) yes ( ) no
Difficulty in opening or closing the mouth? ( ) yes ( ) no
Headaches, neck aches or shoulder aches? ( ) yes ( ) no
Pain? (joint, ear, side of face) ( ) yes ( ) no
Sore muscles? ( ) yes ( ) no

Are you satisfied with your teeth's appearance? ( ) yes ( ) no
Would you like to keep all of your teeth all of your life? ( ) yes ( ) no
Do you feel nervous about having dental treatment? ( ) yes ( ) no
If so, what's your biggest concern?____
Have you ever had an upsetting dental experience? ( ) yes ( ) no

CONSENT FOR TREATMENT

1. I hereby authorize Bosque Dental Care to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Bosque Dental Care to make a thorough diagnosis of (name of patient)____’s dental needs.

2. Upon such diagnosis, I authorize said dentist at Bosque Dental Care to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetics agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18%APR) may be added to my account.

5. **Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

6. **Missed Appointment Fee:** If a patient does not show for any appointment, or cancels with less than **48 hour notice**, a $50 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another dentist.

7. **Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay **ALL** collection cost, which are incurred. If we refer collection of the balance to a lawyer, you agree to pay **ALL** lawyer’s fees, which we incur plus all court cost.

8. **Returned Checks:** There is a fee (currently $25) for any check returned by the bank.

9. **Divorce:** In case of divorce or separation, the party responsible for the account prior to such acts remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the part parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

10. **Transferring of Records:** You will need to request in writing and pay a reasonable copying fee (currently $25) if you want to have copies of your records. You authorize us to include all relevant information including your payment history.

Patient____Date___________Witness__________

Parent or Responsible Party____________________________ Relationship to Patient____________

Bosque Dental Care (912)355-0555

HIPAA OMNIBUS RULE
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FOREM

You May Refuse to Sign This Acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: ____________________________ Patient Name: ____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ oper Sur Name Ot☐r ______________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ____ Relationship: __________________________________

Name: ____ Relationship: __________________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form you acknowledge and authorize that this office may recommend products or services to promote your improve health. This office may or may not receive third party remuneration from these affiliated companies. We under Current HIPAA Omnibus Rule provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_______________________________ _________________________________
Please **print** Name of Patient Please **Sign** for Patient/Guardian of Patient

__________________________________ ___________________________________
Legal Representative/Guardian Relationship of Legal Representative/Guardian

---

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (Please describe) _____

____
Signature of Privacy Officer

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Bosque Dental Care (912)355-0555

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.

THIS 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 is effective as of 01/01/2022, and will remain in effect until we replace it. We reserved 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 series we provide to you.

Health Operations: We may use and disclose your health information in connection with our health operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training program, 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 of 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, or 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, 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 $0.25 for each page, $25.00 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 disclose 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 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 amend or restrict the use of 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

Telephone: (912)355-0555 Fax: (912)353-9042

Address: 723 East 65th Street, Savannah, GA, 31405

Bosque Dental Care

Epworth Sleepiness Scale

Name: ____

Date: ____

Age:________________________________ **Sex: Male** ☐ **Female** ☐

How likely are you to doze off or fall asleep in the situation described below, in contrast to feeling 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 affected 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 DOING
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (ex: a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permits	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a Car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Score:
0-10 Normal Range
10-12 Borderline
12-24 Abnormal

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723 East 65th Street
Savannah, GA 31405
WWW.Bosquedentalcare.com