2017 WELCOME TO THE OFFICE OF PETER A. MCINTYRE D.D.S., P.C.

Please fill out this form completely as it is important to your care.

ABOUT YOU

Today's Date: ____________________________ ☐Married ☐Single ☐Partnered ☐Divorced ☐Separated ☐Widowed

Name: ____ ☐M ☐F Birthdate: ____/____/____ Age: ____ SS#: _____________________
LAST FIRST M.I.

Home Address: ____
STREET CITY STATE ZIP

Home#: (_____)_______________ Cell#: (_____)_______________ Wk#: (_____)_______________ DL#: __________________________

E-mail Address: ____ Best time to reach you? _____________________________________

Whom may we thank for referring you? ______________________________ Other family members seen by us: _________________________

Employer: ____________________________________ How long there? ___________ Occupation: ________________________________

Employer's Address: ____
STREET CITY STATE ZIP

General Doctor: ___________________________________ Previous or Present (Please circle) Date of last visit: ________________________

SPOUSE INFORMATION

His/Her Name: ____ Birthdate: ____/____/____ SS#: _____________________

Employer: ____ Wk#: (_____)_______________ DL#: __________________________

Person responsible for Account, if other than yourself

Name: ____ Relation: ____________________________ SS#: ____________________

Employer: ____ Wk#: (_____)_______________ DL#: __________________________

Home#: (_____)_______________ Billing Address: ____
STREET CITY STATE ZIP

INSURANCE INFORMATION

Primary Insurance Dental Coverage ☐Y ☐N Medical Coverage ☐Y ☐N Orthodontic Coverage ☐Y ☐N

Ins. Co. Name _____________________________ Ins. Co. Ph#: (_____)_______________ Group # (Plan, Local or Policy #)_____________

Ins. Co. Address: ____
STREET CITY STATE ZIP

Insured's Name:________________________________ Relation:___________________ Insured's Birthdate: ___/___/___ SS#: _____________

Insured's Employer: _____________________________________ Employer's Address: ____
CITY STATE ZIP

Secondary Insurance Dental Coverage ☐Y ☐N Medical Coverage ☐Y ☐N Orthodontic Coverage ☐Y ☐N

Ins. Co. Name _____________________________ Ins. Co. Ph#: (_____)_______________ Group # (Plan, Local or Policy #)_____________

Ins. Co. Address: ____
STREET CITY STATE ZIP

Insured's Name:________________________________ Relation:___________________ Insured's Birthdate: ___/___/___ SS#: _____________

Insured's Employer: _____________________________________ Employer's Address: ____
CITY STATE ZIP

HISTORY

Why have you come to the doctor today? ____________________________

____

Are you currently in pain? ☐Y ☐N

Do you require antibiotics before dental treatment? ☐Y ☐N

Have you experienced problems associated with any previous dental work? ☐Y ☐N

Do you now/have you ever experienced pain/discomfort in your jaw (TMJ/TMD)? ☐Y ☐N

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you floss daily? ☐Y ☐N Do you brush daily? ☐Y ☐N

Type of bristles on toothbrush: ☐ Hard ☐Med ☐Soft

How often do you replace your toothbrush? __________________________

Do you use anything in addition to your brush and floss? ☐Y ☐N

If yes, what? ____

Do you want fresher breath? ☐Y ☐N Whiter teeth? ☐Y ☐N

Do your gums bleed? ☐Y ☐N Do gums itch? ☐Y ☐N

Have you ever had periodontal disease? ☐Y ☐N

Do you have mobility in your teeth? ☐Y ☐N

Are your teeth sensitive to heat, cold, or anything else? ____________

Do you still have wisdom teeth? ☐Y ☐N

If yes, why? ____

Previous Dentist:____________________ Date of last visit:_______________

Why did you leave your previous dentist? ______________________________

What did you like most/least about any dentist you have seen?

____

Are you happy with the way your smile looks? ☐Y ☐N

If not, what would you change? __________________________________

Do you have a personal physician? ☐Y ☐N

Physician's Name: ______________________________________

Address: ____

Ph #: (_____)_________________ Date of last visit: ___________

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Y ☐N

Please explain: ____

Do you smoke or use tobacco in any form? ☐Y ☐N

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Dental Anesthetics	

Please list additional drugs/materials that cause allergic reactions:

____

Are you taking any of the following?

Y N Acetaminophen	Y N Antibiotics	Y N Antihistamines
Y N Aspirin	Y N Blood Thinners	Y N Blood Pressure Medicine
Y N Cold Remedies	Y N Digitalis	Y N Insulin/Diabetes drugs
Y N Nitroglycerin	Y N Recreational Drugs	Y N Steroids/Cortisone
Y N Thyroid Medicine	Y N Tranquilizers	

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐Y ☐N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐Y ☐N

If yes, please list each one____

____

WOMEN: Are you taking birth control pills? ☐Y ☐N

Are you pregnant? ☐Unsure ☐Y ☐N Week #: __________

Are you nursing? ☐Y ☐N

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for any reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

______________________________________ ________________

Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____________________________Insurance Co. and I assign directly to Dr. Peter A. McIntyre all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________________ ________________

Signature Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Peter A. McIntyre, D.D.S., P.C.
595 Chapel Hills Drive, Suite 105
Colorado Springs, CO 80920
(719) 475-2511

Financial Policy

We are pleased to have you in our dental practice. Our desire is to provide you with the highest quality care and supply you with the information you need to make the financial decisions regarding your treatment.

It is our policy to make specific financial arrangements with you before any treatment begins. Below is an explanation of the various circumstances that will be involved in making these arrangements.

- **Payment for services is due at the time that services are rendered, including estimated co-payments, should you have dental insurance.** Please make sure you check with the receptionist before leaving. We accept cash, checks, Master Card, VISA, Discover, and American Express.
- We will gladly bill your insurance company for you. **We will estimate your portion, and collect that at each visit. We will not wait on payment from insurance before requesting your portion.**
- Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive depends on the quality of the plan purchased by your employer. These benefits vary greatly, with different rules and regulations for each company. We will do our best to estimate your coverage and portion due, but it is your responsibility to be aware of your policy and its limitations.
- **Payment arrangements may be available, upon prior approval only**. A Truth in Lending Statement must be signed, disclosing the agreement in detail. Dr. McIntyre does not handle the financial arrangements. Please discuss this with the receptionist, who may confer with the Practice Manager as needed.
- There will be a $30.00 fee for all returned checks.
- You shall advise us of changes to your address, telephone number, or any changes in your insurance information. Billing to an incorrect insurance company adds weeks to the processing of your claim. Claims open past 90 days must be paid by the patient, with late insurance payments being forwarded to you.
- **There is a $45 charge assessed for each hour of an appointment cancelled with less than two open-for-business days' notice.** Thursday cancellations for Monday appointments are considered late cancellations as well, as we are not open on Fridays.

Patient Signature: ______________________________________Date:_________________

Peter A. McIntyre, D.D.S., P.C.
595 Chapel Hills Drive, Suite 105
Colorado Springs, CO 80920
(719) 475-2511

HIPAA COMPLIANCY SIGNATURES

I have read and understand Dr. McIntyre's Statement of Privacy Policy.

____ ________________
Signature Date

I authorize Dr. McIntyre to share my dental treatment or concerns with other doctors as he sees fit. Dr. McIntyre may also share my dental records with my insurance company, as it may be necessary to obtain payment or a predetermination.

____ ________________
Signature Date

I authorize Dr. McIntyre to discuss my treatment needs and account information with my spouse or other family member.

____ ________________
Signature Date

We strive to provide the most complete patient experience. Within our practice we utilize photography as a technology to not only assist with the treatment planning process but also as a tool to assist with patient education. These pictures allow the doctors to completely evaluate issues that aren't necessarily captured on radiographic imaging.

We still very much recognize HIPPA guidelines so your photographic information is not shared unless we are given permission to do so. The capacity in which it would need to be shared is, when conferring with other specialists regarding your care, the photos can be utilized as a diagnosing tool.

I give permission to have my photos taken

____________________________________ ______________________________

Signature Date

I DO NOT wish to have my photos taken

____________________________________ ______________________________

Signature Date

Easy Screener Epworth Sleepiness Scale

Name: ______________________________ DOB: ______________

Phone Home: ______________ Work: ______________ Cell: ______________

Address: ______________________________

City, State, Zip: ______________________________

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number for each situation. Write the numbers on each line and add them up on the total line.

Scale for chance of dozing: 0=*never* 1=*slight* 2=*moderate* 3=*high*

Situation	Chance of dozing
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater, meeting)	
Sitting as a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
Sitting in a car while stopped for a few minutes in traffic	
Total Score	

Please Circle One

Do you snore loudly or does it bother your bed partner?	YES	NO
Are you excessively tired or sleepy during the day?	YES	NO
Have you been told you stop breathing during sleep?	YES	NO
Do you wake during the night feeling breathless or gasping?	YES	NO
Do you wake up feeling un-refreshed after a night's sleep?	YES	NO
Do you have a history of hypertension?	YES	NO
Male Gender or Menopausal Female?	YES	NO
Do you have trouble going to sleep or staying sleep?	YES	NO

Epworth Sleepiness Scale of 10 or greater or "Yes" to four (or more) of the circled questions is a positive screen for sleep disordered breathing; you may want to discuss this with your physician.

Patient Signature: ______________________ Date: __________ Time: __________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

PETER A. MCINTYRE, D.D.S, P.C.
GENERAL AND HOSPITAL DENTISTRY

Obstructive Sleep Apnea Screening

Patient Name ______________________________**Date of Birth**___________________

	YES	**NO**
Has anyone told you that you snore loudly?		
Are you male?		
Are you sleepy or do you doze off during the day?		
Are you 50 years or older?		
Has anyone told you that you stop breathing during sleep?		
Do you have high blood pressure?		
What is your height? _________ And your Weight? _________		

I have been previously diagnosed with OSA and am regularly using my CPAP or other OSA therapy
I have been previously diagnosed with OSA and am not using my CPAP or other therapy regularly
Others in my family have been diagnosed with OSA
I have a pacemaker

____ ______________________

Patient signature **Date**

____

Staff Only:

OCR NOTICE OF NONDISCRIMINATION from HHS office for civil rights

Peter A McIntyre DDS PC & Associates

719-475-2511

Our office does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- Our office provides free aids and services to people with disabilities to communicate effectively with us such as:
  - Qualified sign-language interpreters
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters

If you need these services any of our team members can assist you with contacting qualified interpreters to assist you.

If you believe that Peter A McIntyre DDS PC & Associates have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with U.S. Department of Health and Human Services, Office for Civil Rights.

You can also file a civil rights complaint electronically with the U.S. Department of Health and Human Services, Office for Civil Rights through the Office for Civil Rights, Complaint Portal at https://ocrportal.hhs.gov/oct/portal/lobby.isf or mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building. Washington, DC 20201. Toll free: 1-800-868-1019. 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.