Island Point Dentistry LLC, P.A.

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address:

Street/PO Box: _____

City, State, Zip : _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Ext: _____

Email:_____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐ Single

Employment Status: ☐Full time ☐Part-Time ☐Self Employed ☐Retired ☐Student

Person to notify in case of Emergency:_____ Phone:_____

Primary Care Physician Name: _____ Phone:_____

Sleep Physician Name:_____ Phone:_____

Restorative Dentist Name:_____ Phone:_____

Description and Date of last Dental visit:_____

Responsible Party (Complete if someone other than the patient)

First Name: _____Last Name: _____Middle Initial: _____

Address:

Street/PO Box: _____

City, State, Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____) _____

Work Phone: (_____)_____Ext: _____ Email: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

If you have recent dental x-rays from another office, please contact that office and request your x-rays be emailed to info@islandpointdentistry.com

_____ _____/_____/_____

Signature of Patient/Parent/Guardian Date

INFORMED CONSENT FOR THE TREATMENT OF SNORING AND/OR OBSTRUCTIVE SLEEP APNEA WITH ORAL APPLIANCES

PLEASE READ AND INITIAL WHERE INDICATED

1. Snoring and Obstructive Sleep Apnea are breathing disorders that occur during sleep due to narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may be no more problematic than the noise itself. However, snoring may be indicative of a more serious disorder, Obstructive Sleep Apnea (OSA). OSA is a serious condition where the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, this can result in excessive daytime sleepiness, irregular high blood pressure and increased risk of heart attack and stroke. INITIAL_____

2. Because any sleep disordered breathing may potentially represent a health risk, all individuals are advised to consult with their physician and/or sleep specialist for accurate diagnosis of their condition. INITIAL_____

3. Oral appliances may be helpful in the treatment of snoring and sleep apnea. Those diagnosed with mild or moderate sleep apnea are better candidates for improvement with this therapy than those severely affected. Oral appliances are designed to assist breathing by protruding the mandible, keeping the tongue forward, thereby enlarging the airway space in the throat. While clinical research exists that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees this therapy will be successful for every individual. Each person is different and presents with unique circumstances. INITIAL_____

4. Oral appliances will not reduce snoring and/or apnea for everyone. Furthermore, occasionally some patients may not be able to tolerate the appliance in their mouth. Some individuals may develop adverse side effects such as excessive salivation, sore jaw joints, sore teeth and a slight change in their bite. These symptoms usually diminish after appliance removal. On rare occasions, a permanent bite change or damage to the temporal mandibular jaw joint may occur. The cost of managing oral appliance induced conditions is not included in the fee for the appliance. These conditions may require a referral to additional dental specialists for management. INITIAL_____

4. It is advised that the oral appliance should be checked at least two times a year to ensure proper fit and that the mouth and jaw joint be examined at that time to assure a healthy condition. If any unusual symptoms occur, it is recommended that the appliance not be worn until an office visit is scheduled to evaluate the situation. If this occurs, the patient should immediately contact our office. INITIAL_____

5. Individuals who have been diagnosed as having sleep apnea may notice that after sleeping with an oral appliance they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high to prevent abnormal heart rhythms is to have a consultation with the sleep specialist and a follow-up sleep test while wearing the appliance. INITIAL_____

6. In order to diagnose and treat this condition correctly, the doctor should evaluate your jaw joint, airway, soft tissues, and teeth to assess if an appliance will be beneficial. The doctor will obtain and correlate some "baseline" records eg. models of the teeth, photos, x-rays etc. This is in no way a substitution for a comprehensive dental examination or dental treatment. This evaluation is insufficient to detect dental decay, periodontal disease, or oral cancer. Patients undergoing extensive dental work must inform their restorative dentist and the doctor making the appliance prior to their first visit. Oral appliance therapy may affect the patient's dental treatment results. INITIAL_____

7. The doctor may also require the patient to consult with other specialists eg. Sleep Specialists, ENT's, Oral and Maxillofacial Surgeons, Orthodontists etc. prior to fabricating an oral appliance. INITIAL_____

8. The fee for the oral appliance includes diagnostics for suitability, the appliance, and 3 follow up visits within the following 6 month period. It does not include any additional dental treatment or the follow up sleep study. Additional appointments will be subject to additional fees. Repairs to damaged oral appliances are provided at an additional fee. INITIAL_____

By signing below I, the patient, indicate that I have read and understood this information concerning oral appliance therapy for the treatment of snoring and/or sleep apnea. I have had the opportunity to discuss the foregoing conditions and the information concerning the oral appliance.

I understand that I accept any financial responsibility for this therapy and authorize treatment and confirm that I have received a copy of this consent form.

Patient Signature: _____

Printed Name of Patient:_____

Date: _____/_____/_____

Island Point Dentistry LLC, P.A.

MEDICAL HISTORY

PATIENT NAME_____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism Scarlet ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Fever Shingles ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
			◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Please list all medications and note any other medical conditions:

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Island Point Dentistry LLC, P.A.

FINANCIAL POLICIES FOR SLEEP APNEA AND SNORE GUARD ORAL APPLIANCES

Oral appliances for the treatment of mild to moderate sleep apnea have been shown to be effective at reducing apneic events for most patients. We strive to provide high quality durable appliances that can be calibrated for greatest efficacy.

Payment Arrangements:

Patients are financially responsible for all treatment rendered. One half of the fee is due at the initial appointment. The balance is due at the second appointment.

Payment Options:

For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express, Health Savings Account Credit Cards, and Care Credit Financing.

Insurance: We do not participate with Medicare or any other medical insurance; therefore, we are unable to bill or assist you with submitting bills and/or claims for oral appliances to your medical insurance. Medical billing would necessitate an increase in service fees. We have intentionally set our fees at the lowest point to pass that savings on to our patients.

Outstanding Accounts: Any balances more than 90 days old, will be subject to review and collection efforts. If a satisfactory arrangement is not made or upheld, we reserve the right to transfer the account to an outside collection agency. We realize that temporary financial situations may affect your ability to pay your account in a timely manner. If this is the case, please contact us promptly for assistance in the management of your account.

Reservation of Appointments: We do our best to reserve appointment time that accommodates your needs. If you need to reschedule an appointment, we ask that you kindly provide us with at least a 48 hour notice. This courtesy on your part allows us the opportunity to offer this appointment time to a patient in need. If we do not receive adequate notice, we reserve the right to assess a $50 fee for the missed appointment time. We understand that emergencies happen, and will work with you as best as we can.

It is our pleasure to serve your sleep dentistry needs and we welcome any questions or concerns you may have regarding our policies.

I have read, understand, and agree to the policies for Island Point Dentistry LLC, P.A.

_____ _____

Signature of Patient/Parent/Guardian Date

Island Point Dentistry
LLC, P.A.

Acknowledgement of receipt of Notice of Privacy Practices

I have received a copy of Island Point Dentistry LLC, P.A. privacy practices.

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

____Communication barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining the acknowledgement

____Other (specify below)

Date:_____ Employee Name:_____

Island Point Dentistry LLC, P.A.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/14/2014 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protection under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to, but not limited to, a lab, specialist, or pharmacy providing treatment to you. We may also leave you voicemail messages and mail appointment reminder postcards to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We will not use your health information for this purpose without your permission. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
-Prevent or control disease, injury or disability;
-Report child abuse or neglect;
-Report reactions to medications or problems with products or devices;
-Notify a person of a recall, repair, or replacement of products or devices;
-Notify a person who may have been exposed to a disease or condition;
-Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the US Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a

court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We will not use your information for this purpose without your permission.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We will never use your information for this purpose.

Teaching and Educational Purposes. We may use your case and dental records in a non-identifiable manner for educational purposes.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies, If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. You have a right to see our standard fees.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Privacy Official:
Dr. Amanda Rockwood
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110 Main Street, Suite 1218
Saco, ME 04072
(207) 284-4007 (207)284-4096 Fax