Patient Information Form

Today's Date ____________________

Patient Name: First________________________ MI____ Last ______________________Nickname________________

Address: Street__________________________City______________________________State _________Zip_________

Phone: Home___________________________Work____________________________Mobile ___________________

E-mail address____

By Providing your e-mail address you agree to receive *(check one or both)*___ Appointment Reminders ___Practice Newsletter

What is your preferred method of contact? _______ Home Phone _______Work Phone _______Mobile Phone_______ E-Mail

Social Security Number _______________________________________**Date of Birth** ______________________________

Drivers License # ____**State** ___________________________________

Patient Employed By________________________________ **Occupation**__________________ **Phone**______________

Address: Street _________________________City______________________________ State __________Zip _______

Sex _____Male _____Female **Marital Status** ______Married ______Single ______Divorced _____ Separated _____ Widowed

In case of emergency, who should be notified? ____

Relationship to Patient___________________________ **Home Phone**________________ **Mobile Phone** _____________

Is the patient a Minor? ____Yes ____No **Full-time Student** ____Yes ____No **Name of School** __________________

Name of Responsible Party: First__________________________________ Last ____________________________

Date of Birth______________ **Relationship to Patient** ____Self ____Spouse ____Parent ____Other__________________

If patient is a Minor, primary residency ___Both Parents ___Mom ___Dad ___Step Parent ____Shared Custody ____Guardian

Address: *(if different from patient)* Street_______________________ City__________________ State ________Zip _______

Phone: Home _____________________________Work _________________________Mobile ______________________

Employer *(if different from above)*___________________________ **Occupation** _________________**Phone** ____________

Address: Street ______________________________City _____________________________State ________Zip ________

Dental Benefit Plan Information

Primary Dental Plan Name ____**Phone**__________________

Address: Street ____________________________City___________________________ State _________Zip _______

Name of Insured____________________________ **Date of Birth** _________________**ID Number**__________________

Policy Number____________________________ **Patient Relationship to Insured** _______________________________

Secondary Dental Plan Name____ **Phone** _____________________

Address: Street ___________________________City___________________________ State__________ Zip_______

Name of Insured____________________________ **Date of Birth**_______________________ **ID Number** ______________

Policy Number____________________________ **Patient Relationship to Insured**__________________________________

Dental Health History Form

Today's Date________________

Patient Name: First ______________________________MI____ Last ____________________________Nickname__________

What are your goals in coming to our practice today? ____

What is important to you in a dentist or dental practice? ____

What has been your experience with the dentist in the past? ____

Date of last radiographs (x-rays) and exam ____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)*______________________________

Former Dentist ____Phone ______________________________________

Address: Street ______________________________City______________________________ State __________Zip_________

If you left your previous dentist, what are the reasons?____

Have you had problems with prior dental treatment? ____

Are you experiencing any pain now? ______Yes ______No

If yes, please describe____

Have you ever been pre-medicated for dental treatment? ______ Yes ______No

If yes, why? ____

Have you been anxious about having dental treatment? ______Yes ______No

If yes, would you be comfortable sharing why? ____

Would you like to discuss this concern with the doctor to learn about your relaxation options?______________________________

What concerns do you currently have with your oral health or smile? ***(check all that apply)***

____Jaw joint pain
____Clenching or grinding of teeth
____ Discolored teeth
____ Crowding/Crooked teeth
____ Missing teeth
____ Spaces in between teeth
____ Loose tooth/teeth
____ Tooth shape or size

____ Unhappy with appearance of teeth
____ Overbite
____ Underbite
____ Uncomfortable bite
____ Old fillings *(gold or silver)*
____ Old crowns
____ Speech problems
____ Too much gum tissue when I smile

_____Tooth sensitivity to hot/cold or anything else
_____ Food gets caught in between teeth
If yes, where?____________________
_____ Difficulty chewing
If yes, where?____________________
_____ Bad breath
_____ Other______________________________

Have you ever had orthodontic treatment? ______ Yes ______No

If yes, when? ____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?

_____Yes _____No If yes, when? ____

Have you whitened your teeth in the past? ______Yes ______No

If yes, what method? ____

Are you interested in learning more about the following? *(check all that apply)*

_____Teeth Whitening
_____ Orthodontic treatment
_____ Veneers

____ Tooth-colored fillings
____ Dental implants
____ How to prevent periodontal disease

____ At-home oral hygiene care
____ Periodontal treatment during pregnancy
____ Oral hygiene care for infants and toddlers

Medical Health History Form

Today's Date:___________________

Patient Name: First__________________________ **MI**____ **Last** ______________________Date of birth:_______________

Physician's name:____ ______________Physician's phone:_________________

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No Is your general health good? If NO, explain** ____
2. **Yes / No Has there been a change in your health within the last year? If YES, explain** ___________________________
3. **Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain ____
4. **Yes / No Are you being treated by a physician now? If YES, explain** ____________________________________
   Date of last medical exam?________________ **Reason for exam** ____
5. **Yes / No Have you had problems with prior dental treatment?**________ **If YES ,explain**_______________________
   Date of last dental exam ______________**Name of last treating dentist** ______________________________________
6. **Yes / No Are you in pain now?**____________ **If YES, explain** ____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No Chest pain (angina)
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Fever
Yes / No Night sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problems
Yes / No Blood in urine
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficulty urinating
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No Heart disease
Yes / No Family history of heart disease
Yes / No Heart attack
Yes / No Artificial joint
Yes / No Stomach problems or ulcers
Yes / No Heart defects
Yes / No Heart murmurs
Yes / No Rheumatic fever
Yes / No Skin disease
Yes / No Hardening of arteries
Yes / No High blood pressure
Yes / No Seizures
Yes / No Cosmetic surgery
Yes / No Surgeries
Yes / No Hospitalization
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Tumors or cancer
Yes / No Chemotherapy
Yes / No Radiation
Yes / No Arthritis, rheumatism
Yes / No Emphysema or other lung disease
Yes / No Kidney or bladder disease
Yes / No Stroke
Yes / No Eating disorders
Yes / No Osteoporosis
Yes / No Thyroid disease
Yes / No Asthma
Yes / No Hepatitis
Yes / No Sexual transmitted disease
Yes / No Herpes
Yes / No Canker or cold sores
Yes / No Anemia
Yes / No Liver disease
Yes / No Eye disease
Yes / No Transplants
Yes / No Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV
Yes / No Anxiety
Yes / No Depression
Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No Aspirin
Yes / No Darvon
Yes / No Codeine
Yes / No Latex
Yes / No Local anesthetic
(Novocain or Xylocaine)
Yes / No Valium
Yes / No Demerol
Yes / No Penicillin
Yes / No Food
Yes / No Erythromycin
Yes / No Tetracycline
Yes / No Vicodin
Yes / No Percodan
Yes / No Nitrous oxide
Yes / No Metal

Others____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking ____________________

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** ____________________
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**

If YES, explain ____________________

____

Yes / No **Have you ever been pre-medicated for dental treatment?**

If YES, why ____________________

Yes / No **Have you ever taken Fen-Phen?**

If YES, when ____________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**____________________

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature____________________ Date ____________

Physician's Name____________________ Phone Number ____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) ____________________Date ____________

Signature of Dentist ____________________Date____________

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

MEDICAL PLAN INFORMATION

Plan Name____**Phone**________________________________

Address: Street____________________________________ City ___________________State ________ Zip___________

Name of Insured _________________________________ Date of Birth _______________ID Number________________

Policy Number __________________________ Patient Relationship to Insured ______________Deductible Amount_______

____

Whom may we thank for referring you?

____One of our valued patients *(name of patient)*____

____Advertisement _____________________________________Local Dental Society_______________________________

____Our Web site_____________________________________ Other ____

Please list other members of your immediate family who are patients in our practice

________________________ ________________________ ______________________ _____________________

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, money order, Visa, MasterCard, American Express, Discover, CareCredit and Springstone.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50.00 for each half hour scheduled will be assessed. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50.00 for each half hour scheduled will be assessed.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. ________(initial)

I have read the above and agree to the financial and scheduling terms. ________(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One)______ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. ______(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. ______(initial)

Signature____Date ________________________________

Confidential Medical & Dental History for a Minor Patient

Today's Date:________________________________

Patient Name (first, MI, last):__________________________________Date of birth:____________________

Medical History *(Please circle Yes or No for each)*

1. Physician's name:____________________________________ Physician's phone:__________________

2. Date of last medical examination?____Weight:__________________________

3. Patient is in good health? Yes / No **If no, why?**____

4. Patient has regular medical exams? Yes / No

5. Patient is under the care of a physician at this time? Yes / No **If yes, why?**__________________________

6. Patient is up to date with immunizations? Yes / No

7. Patient is presently taking medications? Yes / No **If yes, what and why?**____________________________

8. Patient has allergies (medications, food, latex/rubber)? Yes / No **If yes, what?**__________________________

9. Patient has been hospitalized? Yes / No **If yes, why and when?**____

10. Patient has had any operations? Yes / No **If yes, why and when?**_____________________________________

11. Patient has had general anesthesia? Yes / No

12. If yes, were there any complications? Yes / No **If yes, please explain complications:**__________________

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No Anemia

Yes / No Arthritis, rheumatism

Yes / No Artificial prosthesis, organs, joints, implants, shunts, valves

Yes / No Asthma

Yes / No Blood disorder

Yes / No Blurred vision

Yes / No Bone pain

Yes / No Canker or cold sores

Yes / No Chest pain, tightness, wheezing

Yes / No Diabetes

Yes / No Diarrhea or constipation

Yes / No Ear infections

Yes / No Eating disorders

Yes / No Excessive thirst

Yes / No Eye disease

Yes / No Fainting spells

Yes / No Family history of diabetes

Yes / No Fever

Yes / No Heart defects

Yes / No Heart disease /defects / murmurs

Yes / No Hepatitis

Yes / No High blood pressure

Yes / No Jaundice

Yes / No Joint pain or stiffness

Yes / No Kidney or bladder disease

Yes / No Muscle pain, weakness

Yes / No Persistent cough or runny nose

Yes / No Recent significant weight loss

Yes / No Rheumatic fever

Yes / No Seizures

Yes / No Sexual transmitted disease

Yes / No Shortness of breath

Yes / No Skin disease

Yes / No Spina bifida

Yes / No Stomach problems or ulcers

Yes / No Stroke

Yes / No	Frequent urination	Yes / No	Thyroid disease
Yes / No	Frequent vomiting	Yes / No	Transplants
Yes / No	Headaches	Yes / No	Tuberculosis
Yes / No	Hearing problems, ear pain	Yes / No	Tumors or cancer
Yes / No	Heart attack	Yes / No	Urinary tract Infections

This information will not be released unless specifically authorized by patient.

Yes / No	Treatment for emotional, mental, or physical delays	Yes / No	Anxiety
Yes / No	AIDS/HIV	Yes / No	Depression

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No
14. If yes, explain:____
15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

Dental Health History
16. Is this the patient's first dental visit? Yes / No **Please list the reason for the visit:**________________
17. Date of last dental examination:______________________________________
18. Name of patient's previous dentist:______________________________________
19. Reason(s) for leaving the patient's previous dentist:______________________________
20. Date of last dental radiographs (X-rays): ____________________________________
21. Does the patient respond well to his/her pediatrician or past dentist: Yes / No **If no, please explain:**______
____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Injuries to the face, mouth, or teeth	Yes / No	Habits (cheek biting, lip biting/sucking, tongue thrusting)?
Yes / No	Thumb, finger, or pacifier sucking? Until what age:	Yes / No	Speech Problems?
Yes / No	Missing or extra permanent teeth?	Yes / No	Habit of going to bed with a bottle?
Yes / No	Mouth breathing, snoring, enlarged adenoids or tonsils?	Yes / No	Jaw pain, clenching or grinding of teeth?

22. Do you live in a community with fluoridated water? Yes / No ______Do not know
23. Does the patient drink tap water? Yes / No
24. Does the patient use any fluoride supplements (rinses, vitamins)? Yes / No **If yes, name of product:**
____
25. How often does the patient brush his/her teeth? __________________________________
26. Does the patient floss his/her teeth? Yes / No **If yes, how often?** ________________________
27. Has the patient ever been evaluated for or had orthodontic treatment? Yes / No
28. If considering orthodontic treatment, what would you most like it to accomplish for the patient?
____

Authorizations

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact the patient's physician:

Responsible Party's Signature: ______________________________ Date: ____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my child's dentist of any change in my child's health and/or medication. Further, I will not hold my child's dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Responsible Party Signature (Parent or Guardian): ______________________ Date: ____________

Signature of Dentist: ______________________________ Date: ____________

I have reviewed my child's Health History and confirm that it accurately states past and present conditions.

Parent/Guardian Signature: ______________________________ Date: ____________

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
______	______________________	________________	______
______	______________________	________________	______
______	______________________	________________	______

Russell Cannon DDS

A Professional Corporation
General, Cosmetic & Implant Dentistry

FINANCIAL AND DENTAL INSURANCE POLICY

We are committed to providing you with the best possible dental care. If you have medical and dental insurance, we will gladly help you receive your maximum allowable benefits, thus minimizing your costs. In order to achieve these goals, we need your assistance and understanding of our policy.

Payment for services is due at the time they are rendered unless payment arrangements have been made in advance in written form. We accept cash, check, Visa, MasterCard, Discover, American Express, CareCredit and Springstone. In order to keep our operating costs and ultimately your costs down, we generally do not bill patients. As a courtesy to you, we fill file your insurance claim for you. In order to process your claim, we just have complete insurance information.

Returned checks will be charged a $25.oo fee upon notification to us by the bank, and we may require alternative means of future payments. You are responsible for all reasonable collection cost and attorney fees in the event of any default of balance owed.

When you make an appointment with us, please remember that this time has been reserved for you. A charge of $50.00 will be made for every half hour of your scheduled appointment time for broken or cancelled appointments without 48 hours notice.

We will gladly discuss your proposed treatment and answer any questions relating to your account. We will not perform any procedure without your knowing the cost of the treatment up front.

As far as your insurance is concerned, please understand the following:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule of fees"' which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We do not render our services on the basis that insurance companies will accept or pay all of our fees. Proposed treatment plans are based on services needed.
4. Estimate of co-pays are based on information available at that time. Insurance carriers do not guarantee benefits until claim is processed.
5. If your insurance fails to pay the portion which they are supposed to cover, you are ultimately responsible for the balance due.

We must emphasize that as dental care providers, our relationship is with YOU, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients. ALL charges are your responsibility from the date services are rendered. If questions or concerns arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us.
We are here to help you.

Sincerely,
Russell W. Cannon and Staff

I HAVE READ THE ABOVE CONDITIONS AND AGREE TO THEIR CONTENT.

_______________________________ _______________________________
Patient Signature Date Patient Name (Print)

Payment Options

Our goal is to provide you with optimal care based on your individual needs. We are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To assist you with your healthcare investment, we provide the following payment options:

_____ Option 1 **I wish to pay my patient portion (check, cash, or credit card) when service is rendered.** We will submit your insurance claim and if there is any difference between the portion paid and the insurance payment, you will be billed for that portion or reimbursed in the case of any over payment. ***Please fill in cardholder information below.**

_____ Option 2 I wish to take advantage of the "In-Office Plan" that is a courtesy offered to patients without dental insurance coverage. An additional form covering the details is available upon request. **Fees for services rendered on "In-Office Plan" must be paid in full at time of service. Visa ATM card, Mastercard ATM card, check and cash payment will be accepted.**

_____ Option 3 I wish to make arrangements, upon credit approval, with CareCredit or Springstone to have my dental treatment financed over an extended period of time. **This Option is not available to "In-Office Plan" participants.**

Patient Name____

Patient Signature_________________________________Date________________

Cardholder Information

I authorize Russell W. Cannon, D.D.S. to keep my signature on file and to charge my:
Check One: _____Visa _____ MasterCard ______Discover ______American Express _____CareCredit ____SpringStone

It is my responsibility to notify Dr. Cannon of any credit card changes of any kind. I understand that this form is valid indefinitely unless I cancel the authorization through written notice to Dr. Cannon.

Cardholder Name (as imprinted on card)____________________________________

Cardholder Address____

City_____________________State______________________Zip Code__________

Account Number_________________Expiration Date______Security Numbers (back)_____

Signature____Date______________

QUESTIONNAIRE FOR SNORING

Patient Name______________________________Age____Sex_______Date___________

Epworth Sleepiness Scale Form

How likely are you to doze off or fall asleep in the situations described in the box below, in contrast to feeling just 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 dozing**
Sitting and reading	______
Watching TV	______
Sitting, inactive in a public place (e.g. 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 permit	______
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	_____

Behavior during Sleep

Use the following scale to choose the *most appropriate number* for each situation:

0 = Never during a usual night
1 = Less than once a week
2 = Once to about half the nights per week
3 = Half the nights to almost always
4 = Almost always or every night
? = Don't know or haven't been told

During your usual sleep, you have noticed or have been told you do the following: (0-4,?)

1. Snore loudly ______
2. Stop breathing ______
3. Choke, struggle for breath ______
4. Toss and turn frequently ______
5. Wake up with headache ______

Usual number hours of sleep per night ______________________________

Number of time you rise to use toilet ______________________________

Have you had an overnight sleep test? ______________________________

What other doctors have you seen about your snoring, and what did they advise or do? _______________

____

____

____

____

____

Signature: _________________________________ Date: _________________________________

Russell W. Cannon, D.D.S.
A Professional Corporation

Family & Cosmetic Dentistry
Irvine Family Health Center-Heritage Square Building
14150 Culver Drive, Suite 200
Irvine, CA 92604
949-552-7874

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to both offer our patients a copy of our Notice of Privacy Practices and to obtain your signature that we did offer you this document.

A copy of our Notice of Privacy Practices is available to you and is displayed at all times in our reception area.

This acknowledgement will be kept in your dental file. If you would like a copy, please feel free to request one at any time.

Thank you.

Print Patient Name____

Patient and/or Guardian Signature_______________________________________

Date____

Russell W. Cannon, D.D.S.
A Professional Corporation

Family & Cosmetic Dentistry
Irvine Family Health Center - The Heritage Square Building
14150 Culver Drive, Suite 200
Irvine, California 92604
949-55-BRUSH

LOCAL ANESTHETIC CONSENT FORM

Our office routinely uses local anesthetics to aid in the administration of quality pain-free dental care. Although local anesthesia is extremely safe from a statistical standpoint, complications from the administration of local anesthetic are possible.

Potential common complications include, but are not limited to, pain, swelling and bruising. Rare but more serious potential complications include, but are not limited to, permanent numbness or abnormal sensation as well as life-threatening reactions.

By signing this consent, patient understands the provisions of informed consent as described and has no further questions.

Patient Name (Print): ____

Parent or Guardian Name: ____
*If patient is younger than 18

Signature: ____

Date: ______________________________