Rod W. Gore DDS
cosmetic and family dentistry

Welcome to our office! Please take a few moments to complete the following information so we can take the best care of you. Our goal is to help you reach and maintain maximum oral health.

PATIENT INFORMATION

Name: _____Preferred Name: _____

Male Female Single Married Other Child Date of Birth: _____/_____/_____

S.S. #:_____

Home Address: _____City/St_____Zip:_____

Home#_____Cell#_____Wk#_____

E-mail_____ Best way to confirm your appointment _____

Employer _____Occupation_____

Whom may we thank for referring you? _____

Previous/Present Dentist _____Date of last visit _____/_____/_____Ph#_____

Emergency Contact _____ Ph#_____

INSURANCE INFORMATION

We will assist you in any way possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier. We do our best to make accurate calculations regarding your insurance plan coverage, however regardless of what your insurance plan pays, you are responsible for all fees.

Primary Dental Insurance

Insurance Co. Name_____

Insurance Co. Phone #_____Group #_____

Policy Holder's Name _____Relation_____

Policy Holder's DOB_____/_____/_____Policy Holder's S.S or I.D# _____

FINANCIAL POLICY: Payment is due at the time of service. Please let us know if you have special circumstances and we would be happy to discuss other payment options. For your convenience our office accepts Cash, Check, Visa, MasterCard, American Express and Discover. Third party financing is also available. Please understand that it is your responsibility to carefully review your insurance policy and be aware of your benefits, limitations and restrictions. We are happy to help you submit the necessary claim forms as a courtesy to you. Ultimately this is an agreement between you, your employer and your insurance company.

APPOINTMENT POLICY:

If circumstances occur and it is necessary to change your scheduled appointment, **we kindly request you give us at least 48 hours notice to avoid a cancellation fee.** If there becomes a history of missed or no showed appointments, we reserve the right to charge your account up to the full amount of your scheduled appointment. Patient (Print):

_____Patient Signature: _____Date:_____/_____/_____

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HEALTH HISTORY

Name_____Date_____/_____/_____

Have you had any surgeries or have you been hospitalized in the last 2 years? Yes No

If yes, reason_____

Are you currently receiving medical care? Yes No

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions please indicate yes or no. Your answers are for our records only and will be confidential. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder	Yes	No	Hepatitis, Any Form	Yes	No
Arthritis, Rheumatism or Inflammatory disease	Yes	No	Joint Replacement	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No
Abnormal Bleeding from a Cut	Yes	No	Liver Disease (Jaundice)	Yes	No
Cancer or Tumor	Yes	No	Sore/Enlarged Nodes	Yes	No
Diabetes	Yes	No	Psychosis	Yes	No
Emphysema or Respiratory/Lung Illnesses	Yes	No	Previous Biopsies	Yes	No
Epilepsy	Yes	No	Radiation or Chemo	Yes	No
Fainting or Dizzy Spells	Yes	No	Rheumatic Fever	Yes	No
Glaucoma	Yes	No	Mouth Sores	Yes	No
Abnormal Heart or Previous Endocarditis	Yes	No	H.I.V /AIDS/ARC	Yes	No
Heart Valve or Heart Transplant	Yes	No	Weight Loss/Gain	Yes	No
Congenital Heart Disease	Yes	No	Venereal Disease	Yes	No
Heart Disease, attack, surgery	Yes	No	Other Conditions	Yes	No
Heart Stent, when placed	Yes	No	Recurrent Illnesses	Yes	No
Cosmetic Surgery/Procedure If Yes, Date and Type:	Yes	No			

Are you taking any medications?

Tagament or Prilosec	Yes	No	Barbiturates	Yes	No
Diflucan or Sporonox	Yes	No	St. John's Wort	Yes	No
Biaxin	Yes	No	Serzone	Yes	No
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Bonivia)				Yes	No
If so, when did treatment Begin/End?					
Have you ever taken any prescription drugs such as fen-phen for weight loss:				Yes	No
Do you consume grapefruit juice, grapefruits, or grapefruit extract?				Yes	No

Please list any medications you are currently taking and dosages:

1. _____
2 _____
3. _____
4. _____

Please list any dietary or herbal supplements you are taking, and for what purposes:

1. _____
2. _____
3. _____
4. _____

Have you ever been diagnosed with "high blood pressure /hypertension "? Yes No
What is your normal blood pressure? Today: _____

Are you allergic or have you had a reaction to:

Local anesthetics	Yes	No
Penicillin or other antibiotics	Yes	No
Aspirin, Ibuprofen or Tylenol	Yes	No
Codeine, Valium or other sedatives	Yes	No
Latex or metals	Yes	No

Other _____

Tobacco, Alcohol, Drugs

Do you use Tobacco? If yes circle type: Smoke Chew How much per day? _____ For how long: _____
Do you want to quit using tobacco? Yes No
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? _____
Do you use any mood-altering drugs other than those previously listed? Yes No

Weight and Diet considerations:

Weight: _____ Meals per Day: _____ Dietary Restrictions: _____ Food Allergies: _____
Sugar in your diet: None slight moderate high

Women: Is there any chance you are pregnant? If no, are planning a pregnancy in the near future? Yes No
Are you a nursing Mother? Yes No
Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with the 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 change in my health and medication.

Patient (Print Name): _____ Patient Signature: _____Date: _____/_____/_____

Doctor (Print Name): _____Doctor Signature: _____Date: _____/_____/_____

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____
_____

Significant findings from questionnaire or oral interview:

_____
_____

Dental management considerations:

_____
_____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge I have received a copy of the Statement of Privacy Practices for the office of Rod W. Gore, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. It also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement or Privacy Practices is posted in the facility.

Dr. Rod Gore reserve the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time to my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____ _____

Patient's Name *Date of Birth* *Date*

Legal Representative Information (if applicable):

Name:_____ Relationship:_____

Address:_____

Street *City* *State* *Zip*

I, _____, give my consent and authorization for Dr. Rod Gore and staff to discuss and disclose my personal health information regarding my dental treatment and financial matters related to dental treatment to the following person(s):

ANY MEMBER OF IMMEDIATE FAMILY ☐ YES ☐ NO

SPOUSE ONLY ☐ YES ☐ NO

OTHER (Specify) ☐ YES ☐ NO

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

Signature of Patient or Legal Representative *Date*

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Credit Card Authorization Form

Type of Card: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card Number:_____

Expiration Date: _____

CV Code:_____

Name on Card:_____

Billing Address:_____

City:_____State:_____ Zip Code_____

I, _____, authorize Rod Gore, DDS to charge my credit card above for agreed upon treatment received.

☐ Please call before processing payment.

_____ _____

Patient Signature Date

RodW.Gore DDS
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Epworth Scale

Patient Name: _____ Date: _____

As part of our comprehensive care, we have included the evaluation and treatment of Snoring and Obstructive Sleep Apnea in our practice, and have been amazed at how profound this treatment has improved the quality of life in those we have treated. On average, Sleep Apnea can take eight years from your life expectancy. It also can have debilitating effects on your overall health, including esophageal cancer, cardiovascular disease, hypertension, neurovascular disease, and obesity.

Please answer how likely you are to doze off or fall asleep in the following situations. Use the scale provided here:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Sitting and reading	
Watching tv	
Sitting in a car as a passenger for more than an hour	
Lying down to rest in the afternoon	
Sitting and talking with someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Sitting inactive during a movie or meeting	
TOTAL SCORE	

Please fill out the following questions to the best of your knowledge.

Age _____ Weight _____ Waist size _____

Height _____ Neck size _____

Please check any of your complaints.

Loud snoring ____	Decreased concentration ____	Headaches in the morning ____
Never feel rested ____	High blood pressure ____	Wake up coughing ____
Depression ____	Obesity ____	Daytime tiredness ____
Witnessed apnea ____	Frequent nighttime urination ____	Weight gain ____

Patient Signature: _____ Date:_____

PHOTO/VIDEO RELEASE

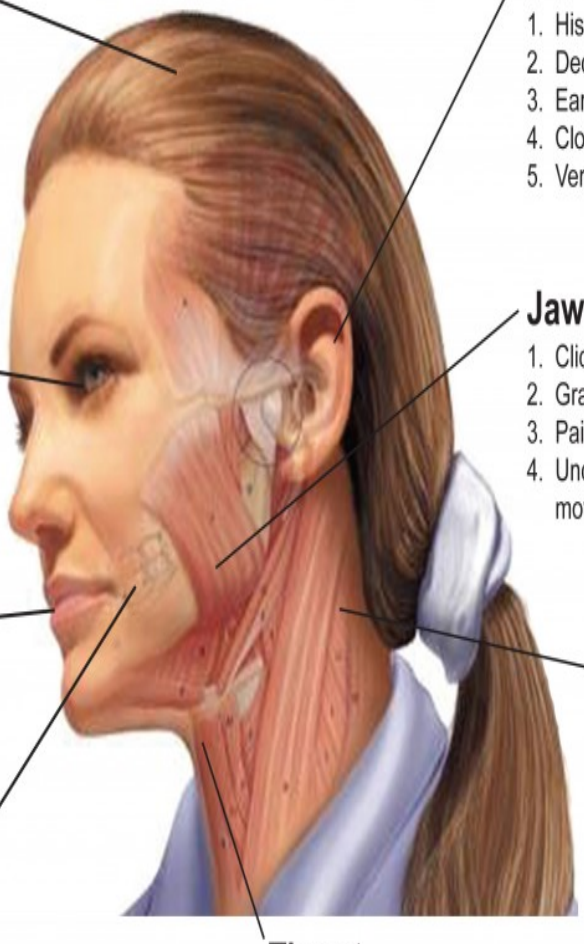
I hereby authorize Dr. Rod Gore and designated associates absolute right and permission to use my photographs/videos for educational or promotional purposes. I completely release any right to present and future compensation in connection with the use of said photographs.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

Patient Name _____ Date _____

Do you suffer from any of the following?



Head Pain, Headache

1. Forehead
2. Temples
3. "Migraine" type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

Ear Problems

1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, ear ache, no infection
4. Clogged, "itchy" ears
5. Vertigo, dizziness

Eyes

1. Pain behind eyes
2. Bloodshot eyes
3. May bulge out
4. Sensitive to sunlight

Jaw Problems

1. Clicking, popping jaw joints
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw and/or tongue movements

Mouth

1. Discomfort
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't find bite

Neck Problems

1. Lack of mobility, stiffness
2. Neck pain
3. Tired, sore muscles
4. Shoulder aches and backaches
5. Arm and finger numbness and/or pain

Teeth

1. Clenching, grinding at night
2. Looseness and soreness of back teeth

Throat

1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Feeling of foreign object in throat constantly