www.SoldotnaDentalArts.com

Thank you for your call to our office. Our office is like no other dental office you have been to before.

We use the latest technology and techniques offered in the field of dentistry. We will take special care and time to make sure you are comfortable with all aspects of your dental visit. We want to exceed all your expectations.

We have experience in many different aspects of dentistry including:

- Crowns (same-day ceramic biocompatible crowns)
- Metal free fillings (do not contain silver mercury)
- Onlays (single visit crown alternatives)
- Root Canals (more comfortable and quicker procedure techniques)
- Extractions (extra training to make it comfortable for you)
- Dentures (implant retained options as well)
- Whitening (how white do you want to go?)
- Smile Makeovers (see our before and afters)
- Implant Restorations (replace one or several missing teeth)

In addition we are continually learning new and advanced techniques in dentistry.

Please help complete the enclosed questionnaire so we can recommend a personalized dental plan based on your needs and wants. We will show you what the possibilities are and it is your decision what treatment you would like to have done. **Please return these to us two days prior to your appointment.** Fax (907) 888-. Email: info@soldotnadentalarts.com. Mail: 35657 Kenai Spur Hwy, Soldotna, AK 99669.

Since you are an active participant in your dental treatment, we want to know what is important to you about your smile. We look forward to meeting you!

Sincerely,

Soldotna Dental Arts

- 35657 Kenai Spur Hwy Soldotna, Alaska 99669 P: (907) 420-3938 F: (888) 565-9547

Questionnaire

Your visit at our office will be the most thorough and detailed dental visit you have ever had. We will be using very and new innovative technology and taking special care to look at your overall oral health. We place high emphasis on helping you determine your present and future dental needs. Here are some of the things we will be discussing at your first visit. These may be questions you have never thought much about. Please circle what best expresses how you feel about the following questions.

- Are you having any areas of concern? (please describe)____
- Tell us in your opinion the present state of health your mouth is:______________________________
- How healthy do you want your mouth to be?

  "Don't really care" Average The Best it can be

- Tell us about your good dental experiences…____
  And the bad ones… ____
- What, if anything, would you like to change about your smile?________________________________
- What would it take for you to trust us?____
- Do you have any family or friends that already come to our office?______________________________
- What do you already know about our office and what are your expectations?___________________
- Have you seen our website @ www.soldotnadentalarts.com?__________________
- Has fear ever been an issue for you in a dental office?____
- Has time ever been a factor in getting your dental work done?________________________________
- Has the cost of dental treatment been a concern for you?______________________________________
  What can we do to help you with this?____
- We have the unique ability to access your mouth from 3 different perspectives. What combinations of these would you like us to use for you? (please circle)

  as a **General** Dentist as a **Cosmetic** Dentist as a **Functional** Dentist

- At what point would you like to initiate treatment?

  When my tooth hurts or breaks When something is worsening When something isn't ideal

- What quality of dentistry would you like us to recommend?

  "Just patch it" Average Ideal/the Best

Is there any additional information you would like us to know?____.

Soldotna Dental Arts
Comprehensive Family Dentistry and Implants

Dental History

Question		
Do you think you have Decay, Gum Disease or Jaw Problems?	Yes	No
Does your floss shred when you use it?	Yes	No
Do your gums ever bleed?	Yes	No
Does food pack or catch between your teeth?	Yes	No
Does your breath concern you?	Yes	No
Do you ever have clicking, popping or jaw discomfort?	Yes	No
Do you clench or grind your teeth?	Yes	No
Have you had braces?	Yes	No
Do you smoke or chew tobacco?	Yes	No
Do you Vape	Yes	No
Are you interested in improving your smile?	Yes	No
Would you like to have whiter teeth?	Yes	No

Medical History

SYMPTOMS

Symptom		
Headaches	Yes	No
TMJ Pain	Yes	No
TMJ Noise	Yes	No
Limited Opening	Yes	No
Ear Congestion	Yes	No
Dizziness	Yes	No
Ringing in the Ears	Yes	No
Difficulty Swallowing	Yes	No
Difficulty Chewing	Yes	No
Loose Teeth	Yes	No
Clenching/Grinding	Yes	No
Bell's Palsy	Yes	No
Facial Pain	Yes	No
Tender Sensitive Teeth	Yes	No
Neck Pain	Yes	No
Postural Problems	Yes	No
Tingling in Fingers	Yes	No
Hot and Cold Sensitivity	Yes	No
Nervousness	Yes	No
Insomnia	Yes	No
Trigeminal Neuralgia	Yes	No
Back Pain	Yes	No
Sinus Problems	Yes	No
Asthma	Yes	No
Snoring	Yes	No
Liver Disease	Yes	No
Angina/Chest Pain	Yes	No
Heart Attack/ Failure	Yes	No
Blood Disease- kind?	Yes	No
Blood Pressure Problem	Yes	No
Bleed Easily	Yes	No
Diabeties	Yes	No
Hepatitis A, B or C	Yes	No
Thyroid Disease	Yes	No
Cold Sores	Yes	No
Fever Blisters	Yes	No
Cancer Kind_________________________	Yes	No
Heart Murmur	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No
Congenital Heart Disorder	Yes	No
Mitral Valve Prolapse	Yes	No
Rheumatic Fever	Yes	No
Lung Disease	Yes	No
Kidney Problems	Yes	No
Heart Pacemaker	Yes	No
Other Heart Conditions________	Yes	No

____

Are you under a physicials care? If so describe____ Yes No
Physicians Name:______________________________ Phone #:______________________________
Have you had a serious accident or hospitalization? If so describe______________________________ Yes No
Are you taking any medications, including asprin or vitamins Yes No
If so Please list the names and dosages ____
__
Do you have any allergies that you are aware of?____ Yes No
Penicillin Codeine Latex Sulfa Metals Acrylic
Women: Are you pregnant or trying? Yes No Nursing? Yes No Contraceptives? ________
Do you see a Chiropracter?____ Yes No
Normal Blood Pressure if known ____/_______.
I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions to the best of my knowledge. I will notify the office of any changes to my health or medications.

__
Patient Signature Date

____
Printed Name

Patient Information

Patient Name:____Date:________________________________
First Middle Initial Last

☐Male ☐Female ☐Married ☐Single ☐Child Other:_________Birth Date:_______________

Social Security #:________________________Drivers License #:_____________________Best time to call:______________________

Email: ____

Phone- Home:________________________Work:________________________ext:____Cell:________________________________

Address:____
Street City State Zip

Referral Information

How did you hear abour us? ☐ WWW ☐ TV ☐ Flier ☐ Location ☐ Other_______________________

☐ Friend/Family--Whom may we thank for referring you to our practice?____

Spouse / Guardian

The Following is for: ☐ the patients spouse ☐ the person responsible for the account

Name:____Date:________________________________
First Middle Initial Last

☐Male ☐Female ☐Married ☐Single ☐Child Other:_________Birth Date:_______________

Social Security #:_______________________________Drivers License #:____________________Best time to call:_______________

Email: ____

Phone- Home:________________________Work:________________________ext:____Cell:________________________________

Address:____
Street City State Zip

Employment Information

The following is for: ☐ the patient ☐ spouse ☐ the person responsible for the account

Employer Name:____Occupation:____

Address of Work:____
Street City State Zip

Insurance Information

Primary

Name of Insured:____Is insured a patient? ☐ Yes ☐ No
First Middle Initial Last

Patients relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other____________________

Name of Insurance Company:____

ID# of insured:________________________________SS# of insured:______________________________Group #:______________

Insured's Birth Date:___________________________

Employeer Name:____

Address of Insured's Work:____
Street City State Zip

Secondary

Name of Insured:____Is insured a patient? ☐ Yes ☐ No
First Middle Initial Last

Patients relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other____________________

Name of Insurance Company:____

ID# of insured:________________________________SS# of insured:______________________________Group #:______________

Insured's Birth Date:___________________________

Employeer Name:____

Address of Insured's Work:____
Street City State Zip

E CRAIG O'DONOGHUE, DDS, PC

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.
THE 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 takes effect (04/01/03), 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. 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 services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, 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 or 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, of 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 messages, 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 $10.00 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 disclosed 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 will 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.

E. CRAIG O'DONOGHUE, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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