

# Hughes Dental Arts Centre

## ABOUT OUR OFFICE

### APPOINTMENTS

Our office hours are 8:00 a.m. to 4:00 p.m., Monday & Wednesday, and 7:00 a.m. to 4:00 p.m. Tuesday & Thursday. We are committed to you and understand that your time is valuable. We ask that you reciprocate that commitment and arrive at your scheduled appointments promptly. Your appointment time is set aside especially for you. Should you need to reschedule an appointment, please give a 48-hour notice. **If a 48-hour notice is not given a fee of \$150 per clinical hour will be required to reschedule the appointment. Further unexcused failed appointments will require payment in full prior to reserving the appointment.**

### FINANCIAL POLICIES

Patients without Dental Insurance: Payment is expected at the time of service.

\*\*Patients with Dental Insurance: We expect your Estimated Co-Pay upon arrival unless other arrangements have been made. We contact your insurance company to receive as accurate an estimate as possible, however, they stress that what they quote is **NOT** a guarantee of payment. They must receive the claim and process it before they will pay for anything. We will continue to complete the claim forms for you and submit them to your insurance company. Please be aware that any amounts not covered by your insurance are the subscriber's responsibility. You are ultimately responsible for your account.

For your convenience, we accept Cash, Debit Cards, Care Credit, Checks, Cashier Checks, Money Orders, Visa, Mastercard, Discover & American Express.

Please be advised that with any returned checks, there will be a \$35.00 service charge added to the amount of the check.

Thank you for your cooperation.

Christopher H. Hughes, D.M.D.

**I have read and fully understand the financial policy as written above. I understand that my account is ultimately, my responsibility.**

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**Responsible Party Signature**

**Date**

**\*\* PLEASE NOTE:** As a courtesy, it is our pleasure to submit claims to all Primary Insurance Companies, however, Secondary Insurance transactions are the responsibility of the employee/patient. We will be happy to provide a printed claim form for you to submit and you will receive secondary insurance reimbursements directly from the insurance company.

**HIPAA OMNIBUS RULE**  
**PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please **print** name of Patient

\_\_\_\_\_  
Please **sign** Patient / Guardian of Patient

\_\_\_\_\_  
Legal Representative / Guardian

\_\_\_\_\_  
Relationship of Legal Representative / Guardian

\_\_\_\_\_  
HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe) \_\_\_\_\_

Signature of Privacy Officer \_\_\_\_\_



# Hughes Dental Arts Centre

Cosmetic Dentistry    Implant Dentistry    I.V. Sedation

## Longevity of Dental Restorations and Maintenance

Changes in oral habits, medical status, oral conditions, or improper home care can all adversely affect the longevity of your dental restorations (crowns, bridges, filling, etc.). This is why it is important to have at least two cleanings and check-up visits per year. There are also other reasons:

- 1.) If a filling or sealant requires replacement within two years, we will replace it at not extra fee or will credit your account for the original procedure.
- 2.) If a crown, veneer, or bridge should require replacement within five years, we will replace it at no extra fee or will credit your account for the original procedure.
- 3.) **The above action is contingent upon keeping at least two maintenance visits per year.**
- 4.) **CAVEAT:** If you have been diagnosed with or have signs of bruxism (teeth grinding) or cinching, the replacement of any dental restoration (crowns, bridges, fillings etc.) done at our office will be at the normal fee, regardless of the amount of time it has been in the mouth.

## Crowns and Future Root Canal Treatment

When a tooth is breaking down, cracked or has a large deteriorating filling, a crown (cap) is the most durable and predictable way of fixing it. However, every dental or medical procedure does carry a risk of complication. When a tooth is prepared for a crown, there is approximately a 5% risk of need for root canal treatment on that tooth in the future. If this should occur a separate fee for root canal therapy would be required.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



PLEASE PRINT

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME				LAST	FIRST	MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)
PREFER TO BE CALLED					HOME PHONE #			CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	E-MAIL		
<b>MARITAL STATUS</b>		PATIENT'S / GUARDIAN'S EMPLOYER					OCCUPATION		
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> UNDER AGE 18									
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #		
SPOUSE'S NAME				LAST	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #		
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE							WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?		

## EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME		RELATIONSHIP
HOME PHONE #	WORK PHONE #	CELL PHONE #

## INSURANCE AND FINANCIAL INFORMATION

<b>INSURANCE COVERAGE</b>		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
<input type="checkbox"/> YES <input type="checkbox"/> NO				
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS	



# DENTAL HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Referred by \_\_\_\_\_ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor  
Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

## PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_
2. Have you had an unfavorable dental experience? \_\_\_\_\_
3. Have you ever had complications from past dental treatment? \_\_\_\_\_
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma? \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

## GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
11. Have you ever experienced gum recession? \_\_\_\_\_
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

## TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? \_\_\_\_\_
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
20. Do you frequently get food caught between any teeth? \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

## BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together? \_\_\_\_\_
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? \_\_\_\_\_
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? \_\_\_\_\_
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
30. Do you clench or grind your teeth together in the daytime or make them sore? \_\_\_\_\_
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

## SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? \_\_\_\_\_
34. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

## DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

YES NO

1. hospitalization for illness or injury \_\_\_\_\_ ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
  - ☐ aspirin, ibuprofen, acetaminophen, codeine
  - ☐ penicillin
  - ☐ erythromycin
  - ☐ tetracycline
  - ☐ sulfa
  - ☐ local anesthetic
  - ☐ fluoride
  - ☐ chlorhexidine (CHX)
  - ☐ metals (nickel, gold, silver, \_\_\_\_\_)
  - ☐ latex \_\_\_\_\_
  - ☐ nuts \_\_\_\_\_
  - ☐ fruit \_\_\_\_\_
  - ☐ other \_\_\_\_\_

3. heart problems, or cardiac stent within the last six months \_\_\_\_\_ ☐ ☐
4. history of infective endocarditis \_\_\_\_\_ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) \_\_\_\_\_ ☐ ☐
6. pacemaker or implantable defibrillator \_\_\_\_\_ ☐ ☐
7. orthopedic implant (joint replacement) \_\_\_\_\_ ☐ ☐
8. rheumatic or scarlet fever \_\_\_\_\_ ☐ ☐
9. high or low blood pressure \_\_\_\_\_ ☐ ☐
10. a stroke (taking blood thinners) \_\_\_\_\_ ☐ ☐
11. anemia or other blood disorder \_\_\_\_\_ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) \_\_\_\_\_ ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis \_\_\_\_\_ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox \_\_\_\_\_ ☐ ☐
15. asthma \_\_\_\_\_ ☐ ☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus) \_\_\_\_\_ ☐ ☐
17. kidney disease \_\_\_\_\_ ☐ ☐
18. liver disease \_\_\_\_\_ ☐ ☐
19. jaundice \_\_\_\_\_ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency \_\_\_\_\_ ☐ ☐
21. hormone deficiency \_\_\_\_\_ ☐ ☐
22. high cholesterol or taking statin drugs \_\_\_\_\_ ☐ ☐
23. diabetes (HbA1c = \_\_\_\_\_) \_\_\_\_\_ ☐ ☐
24. stomach or duodenal ulcer \_\_\_\_\_ ☐ ☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) \_\_\_\_\_ ☐ ☐

26. osteoporosis/osteopenia (e.g., taking bisphosphonates) \_\_\_\_\_ ☐ ☐
27. arthritis \_\_\_\_\_ ☐ ☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) \_\_\_\_\_ ☐ ☐
29. glaucoma \_\_\_\_\_ ☐ ☐
30. contact lenses \_\_\_\_\_ ☐ ☐
31. head or neck injuries \_\_\_\_\_ ☐ ☐
32. epilepsy, convulsions (seizures) \_\_\_\_\_ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) \_\_\_\_\_ ☐ ☐
34. viral infections and cold sores \_\_\_\_\_ ☐ ☐
35. any lumps or swelling in the mouth \_\_\_\_\_ ☐ ☐
36. hives, skin rash, hay fever \_\_\_\_\_ ☐ ☐
37. STI/STD/HPV \_\_\_\_\_ ☐ ☐
38. hepatitis (type \_\_\_\_\_) \_\_\_\_\_ ☐ ☐
39. HIV/AIDS \_\_\_\_\_ ☐ ☐
40. tumor, abnormal growth \_\_\_\_\_ ☐ ☐
41. radiation therapy \_\_\_\_\_ ☐ ☐
42. chemotherapy, immunosuppressive medication \_\_\_\_\_ ☐ ☐
43. emotional difficulties \_\_\_\_\_ ☐ ☐
44. psychiatric treatment \_\_\_\_\_ ☐ ☐
45. antidepressant medication \_\_\_\_\_ ☐ ☐
46. alcohol/recreational drug use \_\_\_\_\_ ☐ ☐

## ARE YOU:

47. presently being treated for any other illness \_\_\_\_\_ ☐ ☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) \_\_\_\_\_ ☐ ☐
49. taking medication for weight management \_\_\_\_\_ ☐ ☐
50. taking dietary supplements \_\_\_\_\_ ☐ ☐
51. often exhausted or fatigued \_\_\_\_\_ ☐ ☐
52. experiencing frequent headaches \_\_\_\_\_ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco \_\_\_\_\_ ☐ ☐
54. considered a touchy/sensitive person \_\_\_\_\_ ☐ ☐
55. often unhappy or depressed \_\_\_\_\_ ☐ ☐
56. taking birth control pills \_\_\_\_\_ ☐ ☐
57. currently pregnant \_\_\_\_\_ ☐ ☐
58. diagnosed with a prostate disorder \_\_\_\_\_ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) \_\_\_\_\_

List all medications, supplements, and or vitamins taken within the last two years

Drug

Purpose

Drug

Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

ASA

(1-6)



Do you snore?        YES    or    NO

Have you been sedated for a medical or dental procedure? YES    or    NO

Where there any complications?

ADDITIONAL MEDICATION LIST

Drug Name and Dosage	Prescribed by:

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For Office Use Only

Initial Vital Signs

DATE: \_\_\_\_\_

BP: \_\_\_\_\_

PULSE: \_\_\_\_\_

SpO2% \_\_\_\_\_

Age: \_\_\_\_\_

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

ASA Category: \_\_\_\_\_

Diabetics: HbA1C Level: \_\_\_\_\_

Anticoagulant Therapy: \_\_\_\_\_