JAMES B. POLLEY, D.D.S.
Smile Artistry

PATIENT REGISTRATION

Patient Information

Patient: _____ Male _____ Female _____
First Name M.I. Last Name "Goes By"

Cell Phone #_____ Work # _____ Home # _____

Email Address _____ Birth Date _____ SSN# _____

Which contact method do you prefer - email, text message, or phone call? _____

Mailing Address: _____
Street Apt. # City State Zip

Employer _____ Occupation _____

What are some of your hobbies and interests? _____

If Patient is a Child, Father's Name _____ Mother's Name _____

Spouse or Person to Contact in the Event of an Emergency

Name _____ Relationship _____ Phone _____

Account Information

Is "Patient" also "Person Responsible"? Yes____ No ____ If Yes, skip this section.

Person Responsible _____ Relationship to Patient _____

Cell Phone # _____ Work # _____ Home # _____

Email Address _____ Birth Date _____ SS# _____

Mailing Address:_____
Street Apt. # City State Zip

Insurance Information

Is Patient also the Insured? Yes ___ No ___ Is there Secondary Insurance? Yes ___ No ___

Name of Insured _____ Employer _____

Birth Date _____SSN# _____*Insurance Company _____

**We'll get the rest of the information about your insurance/benefit plan(s) from your insurance/benefit card(s).*

I understand this office is considered "out-of-network" for all insurance plans.
I agree to be responsible in full for all fees for services provided.

Responsible Person's Signature _____ **Date** _____

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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 read it carefully. The privacy of your health information is important to us.

The Purpose of this Notice:
Federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice to help you understand what our legal duties are, how we will protect your health information, when and how we will share your health information, and your rights concerning your health information.

Uses and Disclosures With Authorization:
You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You can cancel this at any time by notifying us in writing to stop any further use or disclosure. The cancelation of authorization will not affect any information that has already been shared.

Uses and Disclosures Not Requiring Your Authorization - Most Common Reasons:
Treatment: We may share your health information with another dentist, physician or other healthcare provider providing treatment to you. We may also disclose health information to a family member or friend who is involved with your care or payment if we believe it is in your best interest to do so.

Payment: We may share your healthcare information with health plans, insurers, family members and/or friends involved in your care, to obtain payment for services we provide to you.

Healthcare Operations: We may share health information about you to run our practice, including review of our treatment services, training, evaluation of the performance of our staff, quality assurance, financial and billing audits, legal matters, and business planning and development.

Uses and Disclosures Not Requiring Your Authorization - Examples of Other Reasons:

For your treatment and payment

- When you need emergency care
- To tell you about treatment choices
- To remind you about appointments

For Public Health Reasons

- To help researchers study health problems
- To help public health officials stop the spread of disease or prevent injury
- To protect you or another person if we think you are in danger

Other special uses

- To help police, courts and other people who enforce the law
- To obey laws about reporting abuse and neglect
- To report information to the military
- To obey court orders
- For worker's compensation
- To help government agencies review our work and investigate problems help our business partners do their work

Your Rights:

To exercise any of these rights, you must submit a written request to the Privacy Official listed at the end of this Notice.

- You may ask us to give you a paper copy of the Notice at any time.
- You can ask us to place additional restrictions on how we use or disclose your health information to carry out treatment, payment or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions.
- You may ask to restrict the release of your health information to a health plan when you have paid out of pocket in full for items or services.
- You can ask to look at your health information and get a copy of it in a reasonable and mutually agreeable format. You may be charged a reasonable fee to cover the cost of providing copies of your health information. We may deny your request for access to your health information under certain circumstances.
- If you think something is missing from or wrong in your health record, you can ask us to make changes.
- You can ask us to give you a list of the times (after April 14, 2003) that we have shared your health information with someone else. This will not include the times we have shared your information for the purposes of treatment, payment or health care operations.
- You can ask us to mail health information to an address that is different from your usual address or to deliver the information to you in another way.

Our Responsibilities:

- Under the law, we must keep your health information private except in situations like the ones listed in this notice.
- We must give you this notice that explains our legal duties about privacy.
- We must follow what we have told you in this notice.
- We will only use or share the minimum amount of your health information necessary to perform our duties.

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 right, or 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 uses or disclosure of your health information, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services Office. 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.

Contact Information:
Contact Officer: James B. Polley, DDS
Address: 1875 Village Center Circle, #110, Las Vegas, NV 89134
Telephone: (702) 873-0324 Fax: (702) 873-6368
Email: polleydds@gmail.com

We have the right to change this notice and the way your health information is protected at any time, provided such changed are permitted by applicable law. If this happens, we will change the Notice and make the new Notice available upon request.

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Smile Artistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **Notice of Privacy Practices**.

_____
Print Patient Name

_____ _____
Patient Signature Date

OR

_____ _____
Signature of Personal Representative Print Name of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

___ Parent ___ Guardian ___ Power of Attorney ___ Other: _____

Dental Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement

___ A communication barrier prevented us from obtaining acknowledgement.

___ Other: _____

Staff Member Signature _____ Date _____

DENTAL HISTORY

Patient 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, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
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, not enough, or do you have difficulty swallowing or chewing 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?	☐	☐
BITE AND JAW JOINT		
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw 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 more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
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 / nighttime or ever 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?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) 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?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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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
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) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ 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 or soft tissue implant (e.g., joint replacement, breast implant) _____	☐	☐
8. heart murmur, 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 (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g., "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
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 (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	☐	☐
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. difficulties with stress management _____	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
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, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
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, vitamins, and/or probiotics 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)**

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