Ottesen Family Dentistry ** Dr. Pamela Ottesen, DMD * 850-279-6657 * info@nicevilledental.com*

PATIENT REGISTRATION INFORMATION

Today's Date:_____

Patient Information

First Name:	Last Name:	Middle Initial:
Preferred Name:	Birth Date:	Sex: *M / F*
Address:		
City, State, Zip:		
Cell Phone:	Home Phone:	
Email:	Work Phone:	
Soc Sec:	Student Status: *Full / Part*	
Employment Status: *Full / Part / Retired / Not*	Marital Status: *Married / Divorced / Single / Widow / Separated*	
Place of Employment:		
Emergency Contact:	Emergency Contact #:	Relation:

Responsible Party (if someone other than patient)

First Name:	Last Name:	Middle Initial:
Relationship to Patient:	Birth Date:	
Address:		
City, State, Zip:		
Cell Phone:	Home Phone:	
Email:	Work Phone:	

Spouse or Other Guarantor Information (if different from above)

First Name:	Last Name:	Middle Initial:
Relationship to Patient:	Birth Date:	
Address:		
City, State, Zip:		
Cell Phone:	Home Phone:	
Email:	Work Phone:	

Primary Insurance Information

Name of Insured:	Relationship to Patient:
Insured Birth Date:	Insured Address:
Insured Soc Sec:	Insured Phone:
Insurance Member ID:	Insurance Company:
Employer:	Insurance Co. Address:

Secondary Insurance Information

Name of Insured:	Relationship to Patient:
Insured Birth Date:	Insured Address:
Insured Soc Sec:	Insured Phone:
Insurance Member ID:	Insurance Company:
Employer:	Insurance Co. Address:

Patient Name:_____

	Yes	No
1. Do you have a prosthetic joint / implant? . . . . *If yes, describe where*_____	☐	☐
2. Have you had a heart valve replacement or vascular graft?	☐	☐
3. Do you require antibiotics or other pre-med prior to dental visits?	☐	☐
*If yes, list name of prescribing physician*_____		
*Medication prescribed*_____		
4. Are you taking any blood thinners?	☐	☐
5. Have you been treated for periodontal disease (gum disease)?	☐	☐
If yes, list name of dentist / periodontist_____		
Date of last periodontal cleaning_____		
6. Are you currently seeing an orthodontist?	☐	☐
7. Are you currently wearing braces?	☐	☐
*If yes for #6 or #7, list name of orthodontist*_____		

8. Whom may we thank for referring you to our office?

☐ *Family Member*_____ ☐ *Doctor*_____ ☐ *Online Review*

☐ *Friend / Coworker*_____ ☐ *Other*_____ ☐ *Insurance*

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any other member of her staff responsible for any errors or omissions that I have made in the completion of this form.

X X

Signature of Patient (Parent or Guardian, if Minor) **Date**

COMMUNICATION SYSTEM CONSENT

I authorize my doctor and her designated staff to contact me via text and/or email through automated services.

☐ *Text* ☐ *Email* ☐ *None*

X X

Signature of Patient (Parent or Guardian, if Minor) **Date**

COMMUNICATION

We may have to disclose your health information and billing records to another party if they are potentially responsible for payment on your account. Please list any additional persons we can communicate this information with. This consent will remain in effect until we receive written communication revoking this authorization. If there is no one you would like us to communicate with, please write "None".

Name:	Phone:	Relation:
Name:	Phone:	Relation:

X X

Signature of Patient (Parent or Guardian, if Minor) **Date**

AUTHORIZATION

I authorize my doctor and her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X X

Signature of Patient (Parent or Guardian, if Minor) **Date**

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices is posted for my review and a hard copy is available upon request. I hereby authorize Dr. Ottesen's office to bill my insurance for reimbursement for all benefits that may be due and payable under insurance coverage for the patient listed above.

X X

Signature of Patient (Parent or Guardian, if Minor) **Date**

Ottesen
FAMILY DENTISTRY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY: THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.
Your authorization: Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice. 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.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section in this notice. We my disclose your health information to a family member, friend or other person involved in your treatment to the extent necessary to help with your healthcare only if you allow.
Persons Involved in Care: 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 prescriptions, dental supplies, x-rays, or other similar forms of health information.
Email Communications: We may disclose your health information, through email communication to other healthcare providers for the purpose of providing treatment. This may include, but not limited to, sending x-rays and/or minimal personal information to other providers via email.
Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.
Require 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 or other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health and safety or the health and 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 by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Patient's Rights Access: You have the right to obtain your health information. Contact us using the information listed at the Notice for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 years.

Restriction: You may request that we place additional restrictions, but if we do, we will abide by our agreement (expect in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may 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.

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 rights, 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 use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may correspond to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Ottesen Family Dentistry HIPPA Privacy Officer: E. Darlene Taylor

Phone: 850-279-6657

Hard Copy Available Upon Request.

Revised 11/30/2021

About Our Financial Arrangements and Appointment Policy:
(This Arrangement will supersede previous Arrangements)

To assure a mutual understanding of our fee structure and payment requirements, we ask each patient to read this brief explanation.

***Payment for services** is due at the time treatment is rendered unless payment arrangements have been approved in advance by our Administrative team members. We accept cash, checks ($35 returned check fee), Visa, MasterCard, Discover Card, American Express or Care Credit.

***For Our Patients without Dental Insurance**: Patients will be responsible for paying for your dental treatment at the time of service in full. As well as Cash, Credit Cards, and Checks, we are proud to offer our 12 Month Dental Benefit Plan or Care Credit.

***For Our Patients with Dental Insurance:** We will file your insurance as a courtesy for you as long as you provide us with the proper information prior to your visit. We are currently in network with Cigna and MetLife Insurance companies. (Insurance companies, that our office is In Network with, are subject to change per contract). We do expect payment of your deductible and any other patient portion not covered by your policy for treatments/services provided.

Please understand that your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract and cannot be responsible for lapse of coverage or policy restrictions. We cannot be responsible for non-payment by your insurance company for any reason. **We must emphasize that as a dental care provider, our relationship is with you, the patient, not your insurance company.** Should any problems arise with a claim, we encourage you to contact your insurance company promptly for assistance.

Patient Refund Policy: In the event there is a patient credit, after the patient account is audited, the patient has the option to either: leave the credit on their account, pick up a refund check at our office, or have the refund check mailed to them. I understand and agree that there can be up to 30 days once the request is received before receiving the refund.

Appointments: It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. We do require 24 hours notice for cancellations and reschedules. This time is necessary to allow us adequate time to reach out to other patients in need. **Chronically missed, or cancelled appointments, could result in a $50 fee for each missed appointment after two.**

I hereby authorize Dr. Ottesen's office to bill my insurance for reimbursement for all benefits that may be due and payable under insurance coverage for the patient listed below.

Please sign and date you have read and agreed to terms and conditions above.

Patient Name_____

Patient Signature_____ Date_____

Revised: 5/1/2020

Ottesen
FAMILY DENTISTRY

Pamela Ottesen, DMD, PLLC
1536 John Sims Parkway
Niceville, Florida 32578
PH: 850-279-6657 FX: 850-279-6638

info@nicevilledental.com
(Send films to this email)

(PLEASE SEND ALL FILMS REGARDLESS OF WHEN TAKEN-THANK YOU)

To whom it may concern: The patient listed below requests to have all radiograph records released to our practice. The patient listed is a current patient of record at our dental practice. We would like to review previous radiographs so that we are able to more accurately follow periodontal health and the patient's restorative needs - **FOR PERIO PATIENTS: PLEASE INCLUDE PERIO CLINICAL NOTES TO INCLUDE SRP AND PERIO MAINTANENCE TREATMENT.**

To our valued patient: If the films obtained are not legible to read or incomplete we reserve the right to take additional x-rays for diagnostic purposes which may result in additional out of pocket expense.

Respectfully, Pamela Ottesen, DMD, PLLC

Patients Name:_____ DOB: _____

Patients Signature: _____

Date: _____

Dentist's Name or Name of Practice:_____

Phone Number: _____

Fax Number: _____

Email: _____

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)		
☐ 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, 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. poly cystic ovarian syndrome) ____	☐	☐
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) _____	☐	☐

	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 (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 or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD diagnosis _____	☐	☐
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 or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (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, 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)**

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 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, 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 do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
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?	☐	☐
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 try to 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?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
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?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____