TAOS DENTAL GROUP

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Welcome to Taos Dental Group!

We look forward to caring for you and your families' oral health.

I want to let you know a few things about our practice. The practice has three doctors and five hygienists. Each Provider has his or her own unique personality and follows the Standard of Care set by the American Dental Association. You may have a preferred doctor and hygienist or see the first available. Please let us know your preferences.

The practice has the latest proven technology such as digital radiographs that have 90% less radiation, 3D imaging, and a digital scanner so we don't have to use gooey impression material. All of the doctors are able to use digital technology to place guided implants here in Taos. We use the highest level of infection control using a plant-based product called Biosurf. This is the most effective product in the US.

Taos Dental Group makes the financial aspect as easy as possible, by verifying your insurance benefits prior to your appointment, accepting cash, checks and all major credit cards and Care Credit. We do expect to be paid at the time of service. There is a pre payment courtesy at the time of scheduling for some procedures. We can help you apply for financing if needed.

Our mission statement is to provide quality, compassionate care in a friendly environment in our Taos, Santa Fe, and Red River offices. If there is anything we can do to make you more comfortable please let us know.

We are excited to care for you and your family,

Respectfully,

Dr. Justin Nylund

New Patient Intake Form

General Information	
First Name	Last Name
Nick Name	Date of Birth
Address 1	Address 2
City, State Zip	
Email Address	Home Phone #
Cell Phone #	Work Phone #

Insurance		
Guarantor	Guarantor DOB	Guarantor SS#
Insurance Carrier	Employer Group	
Group #	800 Number for Insurance Verification	

Medical History	
Any medical history that requires pre-medication? ☐ Yes ☐ No Notes:	Are you experiencing any pain or have an area of concern? ☐ Yes ☐ No Notes:
Date of last dental visit	
Other Notes:	

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:

PERSONAL HISTORY	YES	NO
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	**YES**	**NO**
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	**YES**	**NO**
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	**YES**	**NO**
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	**YES**	**NO**
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 _____

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)

TAOS DENTAL GROUP

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Phone 575-758-8303 • Fax 575-737-0970

TaosDentalGroup.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Taos is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Taos and will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
- Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share health information for certain situations, such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
- Comply with law. We can share information about you if state or federal law requires is, including the Department of Health and Human Services.
- Do Research. We can use and share information for health research.
- Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
- Organ and tissue donation requests. We can share information about you to organ procurement organizations
- Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security)
- Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights, we typically use or share your health information in the following ways:

- Get an electronic or paper copy of your medical information. You have the right to inspect and/or obtain a copy of your medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) of your medical information, we may charge you a reasonable, cost-based fee.
- Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
- Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no.
- Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.

• Privacy Notice. You can ask and receive a paper copy of this notice at any time.
• Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases we will never share your information unless given written permission: Marketing purposes, fundraising, and the sale of information.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:
• If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
• If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice of Privacy Practices. We will not share your information other than described in here unless we receive written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Thomas Southam by mail at: 1392 Weimer Road or telephone at 575-758-8303. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

_____

I have read and understand the above information.

_____ _____
First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Date

For office use only

The following patient/authorized representative _____

☐ Refused to sign the Notice of Privacy Practices because _____

☐ Was unable to sign the Notice of Privacy Practices because _____

Financial Policy

PATIENT NAME_____ **DATE** _____

Dental treatment is an excellent investment in an individual's medical and psychological well-being. We realize that everyone's personal financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the care you need and/or desire.

Insurance: We are happy to filed the forms necessary to see that you receive the full benefits of your insurance coverage; however, **we cannot guarantee any estimated coverage as that is the insurance company's provided estimate.**

1. Your insurance policy is an agreement between you, your insurance company; and your employer if applicable
2. We ask that all patient accept direct responsibility for all charges.
3. You are required to meet the deductible, co-payments, and/or percent of estimated fees and non-covered services if applicable.
4. If for some reason your insurance company has not paid their allowed benefits within 90 days from the start of treatment and/or you are denied benefits, you are responsible for your account balance.
5. It is the patient/subscriber/cardholder's responsibility to notify our office if there are any insurance changes.

We are happy to presents you with 2 options in handling your insurance

1. We will prepare everything needed and send all information to the insurance company for you. We will collect your portion at the time of service and accept assignment of benefits from your insurance company. If for any reason the insurance pays differently then they instructed our office, we will bill you for the remaining amount due.
2. We will prepare everything needed and send all information to the insurance company for you. We will collect our entire office fee at the time of service and the insurance company will send you a reimbursement check.

No Insurance: If you do not have insurance coverage; are not sure of coverage; or we are unable to verify insurance for services rendered, you are responsible for all fees. You accept the fees that have been presents to you by Taos Dental Group. You agree that Taos Dental Group will not be financially responsible for any balances associated with your account and will not reimburse you, if a crown or prosthesis is started and not completed. * We are happy to offer a 2% discount for services provided in one visit over $200 paid in full at time of service.

Please note: Patients will be charged a $30 late cancellation fee for appointments cancelled without a 24 hour notice

Date: _____ Patient or Responsible Party:_____

Epworth Sleepiness Scale[11]

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

Name _____

Height _____ Weight _____

Age _____ Male / Female _____

STOP- BANG Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2