Morgan & Presley Dental

Jaimee Morgan DDS • Stan Presley DDS

Today's Date: _____

Patient Information

Patient Name_____

Address _____ City _____ State _____ Zip Code _____
Marital Status (Please Circle): Single/Married Sex (Please Circle): Male/Female

Email Address_____ Home Phone_____

Work Phone _____ Cell Phone _____ Date of Birth _____
Your email address and phone will be used for appointment reminders and texts related to balances due, account info and practice updates.

Social Security # _____ Driver's License # _____ State of Issue _____
I understand I may be contacted by mail, phone or text about my account, any balances or treatment plans.

We Appreciate Referrals! Whom May We Thank for Introducing You to Our Office?

☐ Friend/ Family/ Acquaintance: Please list who we may thank _____

☐ Direct Mailer ☐ Internet ☐ Other Please describe _____

Responsible Party Information

****Please complete any sections that are different than the information listed above. ****

Person responsible for payment of services_____

Relationship to patient (Please circle one): Self Parent Guardian Spouse

Address _____ City _____ State _____ Zip Code _____

Email Address_____ Home Phone_____
Work Phone _____ Cell Phone _____ Date of Birth _____

Social Security # _____ Driver's License # _____ State of Issue _____
Employer Name _____ Employer Address _____

Insurance Information

Please present your insurance card to our office personnel

Name of Insured_____ Relationship to patient: Self Parent/Guardian Spouse

Date of Birth _____ Subscriber Social Security #_____

Insurance Company_____ Subscriber ID _____Group ID _____

Provider Phone # _____ Claims Address _____
I _____ attest that the information I have given you is current and accurate and my dental insurance is active and correct. I understand that I will be held financially responsible for my account if my dental insurance information is inaccurate and/or will not cover my procedures. We are not responsible for how your insurance pays out. You are responsible as the patient to know and understand your benefits.

_____ _____
Patient, Parent, or Legal Guardian Date

Patient History

Dental History

- When was your last dental exam? Last visit _____/_____/____
- Name of previous dentist (optional) _____
- Do you experience severe nervousness or anxiety when visiting the dentist? O YES O NO

Medical History

Medical doctor's name_____

Address_____ Phone number_____

- Are you under a physician's care now? Why?_____ O YES O NO
- Have you been hospitalized or received a blood transfusion? When_____ O YES O NO
- Are you allergic to any medication or substances? Please list_____ O YES O NO
- Do you have an allergy to latex?

  O YES O NO
- Are you taking any medications, pills, or drugs? Please list_____ O YES O NO
- Are you pregnant (female) If so what is your due date? _____ O YES O NO
- Have you had any surgery including cosmetic surgery? _____ O YES O NO
  - If so, what type & when? _____
  - Were there any complications related to the surgery? If so, please elaborate.

    _____

Please circle if you (patient) have or have ever had any of the following:

Alcoholism	Frequent Cough	Nervousness
Allergies to medication	Glaucoma	Jaw Pain (TMJ)
Alzheimer Disease	Gout	Parathyroid Disease
Anemia	Heart Murmur	Psychiatric Care
Arthritis	Heart Pacemaker	Scarlet Fever
Artificial Heart Valve	Heart Surgery	Sickle Cell Anemia
Artificial Joints	Hemophilia	Steroid Therapy
Asthma	Hepatitis A,B,C,or D	Sinus Trouble
Blood Transfusion	High Blood Pressure	Stroke
Bruise Easily	HIV/AIDS	Swelling of Feet, Hands, or Ankles
Chemotherapy or Radiation	Hypoglycemia	Tetracycline
Congenital Heart Problems	Kidney Trouble/Disease	Tuberculosis
Cortisone Therapy	Liver Disease	Thyroid Disease
Diabetes	Low Blood Pressure	Ulcers
Drug Addiction or Substance Abuse	Lung Disease	Venereal Disease
Emphysema	Recent Weight Loss	Cobolt Treatment
Epilepsy/Seizures	Rheumatic Fever	Yellow Jaundice
Excessive Thirst	Minocycline	Fosomax Therapy
Fainting/Dizziness		Other _____
Fever Blisters/Cold Sores	Mitral Valve Prolapse	Other _____

Emergency Contact Information

Please list information of the best person to contact in case of an emergency:

Name: _____

Relationship: _____ Cell phone number: _____

Home phone number: _____ Work phone number: _____

Email Address: _____

Patient Consent

Patient's Name_____ **Date** _____

I hereby grant permission for Dr. Stan Presley, Dr. Jaimee Morgan, and/or any other dentist and associates who is working with him or her to administer anesthetic and other drugs or pharmaceuticals, to remove any tissue and/or structure(s), to use such operative and technical procedures necessary to complete a diagnosis and/or recommended treatment, and to accept the sequence in which the diagnosis and treatment plan will be accomplished. I also grant my permission to Presley Orthodontics, Dr. Stan Presley, Dr. Jaimee Morgan, and/or any other dentist who is working with him or her to acquire and use all or any part of my records, photographs, video tapes, films, digital images, etc., which may be required for examination, diagnosis, treatment and/or teaching presentations.

Patient/Guardian Initials _____

I authorize Presley Orthodontics, Dr. Stan Presley, Dr. Jaimee Morgan, and/or such associates or assistants as he or she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, orthodontic, or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative, operative, restorative, orthodontic, and surgical procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient/Guardian Initials _____

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. As a courtesy we will bill your insurance for the treatment you receive. We do not have control over how your insurance pays. You are responsible as the patient to know and understand you own benefits. We expect you to pay your estimated co-pay at time of service. If your insurance pays less than expected, denies payment or fails to respond to the claim submitted, you are responsible for paying the remainder balance within ten (10) days of billing. A late payment fee equaling 10% of the unpaid balance will be applied to your account at the first of each month if a balance remains unpaid after the ten-day billing period. In Consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time the services are rendered, or within ten (10) days of billing if credit shall be extended. I agree to pay the remaining balance plus attorney fees, court costs and any collection fees (40% Percent of the balance on my account), if the account is assigned to a collection agency or attorney.

I authorize the release of financially identifiable information concerning my account, including charges billed, and payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

Patient/Guardian Initials _____

By signing this you agree and adhere to Morgan and Presley Dental health history, consent to treat, and financial agreement.

Signature_____ Date_____

Patient, Parent, or Legal Guardian

PRIVACY NOTICE

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.

Your protected health information (i.e. individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more on the following respects:

- To other health-care providers (i.e. oral surgeon, another dental office, etc.) in connection with our rendering dental treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you by phone, email or texts.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules;

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of the Privacy Notice and to make the new notice provisions effective for all protected health information maintained by our office and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are **not obligated** to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if; for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This Privacy Notice is effective as of the date of your signature. If you have any questions about the information in the Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed and understand this Privacy Notice.

Signature_____ Date_____

(Patient, Parent, or Legal Guardian)

Morgan & Presley
Dental

CONSENT FORM
In-Office Power Whitening

Patient Name: _____ Date: _____

This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure. My dentist has informed me that my teeth are discolored and could be treated by in-office whitening (also known as "bleaching") of my teeth.

DESCRIPTION OF THE PROCEDURE
In-office tooth power whitening is a procedure designed to lighten the color of my teeth using a hydrogen peroxide gel. During the entire treatment, a plastic retractor will be placed in my mouth to help keep it open and the soft tissues of my mouth (gum tissue) will be covered by a light cured resin barrier to ensure they are not exposed to the whitening gel. After the treatment is completed, the retractor and all gel and tissue coverings will be removed from my mouth. **I understand that the results of my *In-Office Power Whitening* Treatment cannot be guaranteed**.

ALTERNATIVE TREATMENTS
I understand I may decide not to have the ***In-Office Power Whitening*** treatment at all. I understand there are alternative treatments for whitening my teeth for which my dentist can provide me additional information. These treatments include:

Take-Home Whitening Kits
Prefilled Disposable trays

However, should I decide to undergo this procedure, I understand that in-office whitening treatments are considered safe by most dental professionals. I understand that although my dentist has been trained in the proper use of the tooth whitening treatment is not without risk. I understand that some of the potential complications of this treatment include, but are not limited to:

Tooth Sensitivity/Pain – During the first 24 hours after ***In-Office Power Whitening*** treatment, some patients may experience some tooth sensitivity or pain. This is normal and is usually mild, but it can be worse in susceptible individuals. Normally, tooth sensitivity or pain following an ***In-Office Power Whitening*** treatment subsides within 24 hours, but in rare cases can persist for longer periods of time in susceptible individuals. People with existing sensitivity, recession, exposed dentin, exposed root surfaces, cracked teeth, open cavities, leaking fillings, or other dental conditions that cause sensitivity may find that those conditions increase or prolong tooth sensitivity or pain after In-office Power Whitening treatment.

Dry/Chapped Lips – The ***In-Office Power Whitening*** treatment usually takes approximately 1 hour per appointment during which the mouth is kept open continuously for the entire treatment by a plastic retractor. This could result in dryness or chapping of the lips or cheek margins, which can be treated by application of lip balm, or petroleum jelly.

The basic procedures of In-Office Power Whitening treatment and the advantages and disadvantages, risks and known possible complications of alternative treatments have been explained to me by my dentist and my dentist has answered all my questions to my satisfaction. As a general precaution, we do not provide In-Office Power or home bleaching to pregnant women.

In signing this informed consent, I am stating I have read this informed consent (or it has been read to me) and I fully understand it and the possible risks, complications and benefits that can result from the ***In-Office Power Whitening***.

INFORMED CONSENT DISCUSSION FOR TOOTH WHITENING (BLEACHING)

Facts for Consideration

Patient initials
Required

_____ I understand yellow and brown stains usually lighten better than gray or blue stains. Some stains return after treatment is discontinued. Retreatment may be required. Teeth with multiple colorations, bands, or spots due to tetracycline use or fluorosis (discoloration of tooth enamel) may not respond as well and may need multiple treatments or may not whiten at all.

_____ I understand that teeth with many fillings may not lighten.

_____ I understand that whitening treatments only lighten the natural tooth structure and cannot lighten crowns, veneers, composite, or other restorative materials.

_____ I understand professional in-office whitening may require more than one office visit

_____ If I choose to participate in an at-home whitening program, I understand there are specific instructions that I must follow. Drs. Morgan or Presley has given these instructions to me, and I understand my responsibility when using these products.

Benefits of Whitening, Not Limited to the Following:

_____ I understand that participating in whitening treatments can whiten my teeth, giving me a healthier-appearing smile.

_____ I understand that whitening with the bleaching systems used by Presley Orthodontics Family & Cosmetic Dentistry may lead to harder stronger enamel with increased resistance to tooth decay.

Risks of Whitening, Not Limited to the Following:

_____ I understand tooth whitening is unpredictable and there are no guarantees that tooth whitening will work, although the research shows a 97% success rate.

_____ I understand tooth whitening may cause teeth to become sensitive, although this is usually a temporary condition. Should sensitivity occur and persist for any length of time, I will notify Drs. Morgan or Presley.

_____ I understand that the gums and/or soft tissue in my mouth may be exposed to the various agents used in whitening procedures which may cause allergic response or inflammation. If this happens, I will contact Drs. Morgan or Presley.

_____ I understand it is impossible to place a specific time frame on how long the lightened appearance of whitened teeth will maintain the lightened shade. These time periods may vary depending on conditions that exist from my habits and circumstance (For example, daily coffee drinking, smoking, or genetics) which may be internal, external, or both.

_____ I understand that professional application of whitening products can result in my mouth being open for extended periods of time. If my jaw becomes sore, I will notify Drs. Morgan or Presley immediately. Also, my lips may become dry or chapped. This can be treated by application of lip balm.

Consequences if no Treatment is Administered, Are Not Limited to the Following:

_____ I understand if I do not participate in whitening procedures, my tooth color will remain the same or continue to discolor further.

Alternatives to Tooth Whitening, Are Not Limited to the Following:

_____ I understand that depending on the reason I have my teeth whitened, alternatives may exist including, but not limited to, bonding, crowns, and veneers. I have asked my dentist about them and their respective expenses. My questions have been answered to my satisfaction regarding the procedures and their risk, benefits, and costs.

No guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve the conditions(s) listed above. I have had my questions answered to my satisfaction

_____ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

OR

_____I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

_____ _____

Patient's Signature (or Patient's Guardian) Date

I attest that I have discussed the risks, benefits, consequences, and alternatives of whitening with _____(patient's name), who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____ _____

Witness' Signature Date

Bleaching in Our Office

Personalized bleach trays

If I have opted in to do the at-home personalized bleaching trays.

- I will schedule an appointment to have impressions taken of my teeth to be made into a mold that Morgan & Presley Dental will fabricate into Bleach Trays.
- When my trays are ready to be picked up, I will come into the office for home-care instructions and to have the trays delivered to me.
- The first 4 syringes of bleaching material are complimentary, with an additional 2 syringes at every 6 months checkup and cleaning if desired.
- Additional bleach is $20.00 (2 syringes)
- Your bleach trays are made using the best possible material. If they are lost or damaged, call our office to schedule an appointment. There will be a charge per replacement $50.00 each time.

I understand I have 30 days to pick up my bleach trays or they will be disposed of.

_____

Initials

In Office power Whitening

I understand Morgan and Presley Dental provides **TWO** In-office power whitening sessions every 6-month recare visit complimentary to me as long as I am updated and current patient. Additional treatments are $75.00 as long as I am a current and updated patient.

_____

Initials

If I "NO SHOW" to an appointment or cancel less than 24 hours I understand my In-office Power Whitening privileges will be revoked. If I wish to continue bleaching, I will pay $99.99 per session.

_____

Initials

Non-Patient treatments are $350.00 per session.

- Each appointment is one hour long, if I am later than 5 minutes to my appointment, I understand it will be rescheduled.
- In-office power whitening treatment usually takes approximately 1 hour per appointment during which the mouth is kept open continuously for the entire treatment by a plastic retractor.
- During the first 24 hours after in-office power whitening treatment, some patients may experience some tooth sensitivity or pain. This is normal and is usually mild, but it can be worse in susceptible individuals.
- The basic procedures of in-office power whitening treatment and the advantages and disadvantages, risks and known possible complications of alternative treatment have been explained to me by my dentist and all my questions have been answered to my satisfaction.
- I understand Morgan and Presley Dental does not provide in-office power whitening or at home bleaching to pregnant women.

_____ _____

Signature Date

Presley Orthodontics
Family & Cosmetic Dentistry

Missed Appointments & Cancellation Policy

We are so glad that you have chosen us for your dental care! We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our clinicians' time, we have adopted the following policies:

Please Initial the following:

_____ • **24-hour advance notice is required** when cancelling an appointment. This allows us to offer the appointment to another patient. **You may not cancel by text or voicemail. If it is a Monday appointment you must cancel by the Thursday before.**

_____ • If you fail to keep your appointment, a missed appointment fee will be charged. This fee is **$50.00** per hour that your appointment. Is scheduled (example: a crown is 90 minutes; the fee would be $75.00)

_____ • Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

_____ • **Arriving late:** Appointment times have been arranged specifically for you. If you arrive late, your appointment may be shortened or require rescheduling in order to accommodate others whose appointments follow yours.

Signature_____ _____

Patient, Parent, or Legal Guardian Date