



Dental History

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

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 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) _____ | <input type="radio"/> | <input type="radio"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="radio"/> | <input type="radio"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="radio"/> | <input type="radio"/> |
| 5. Have you ever had braces, orthodontic treatment or your bite adjusted? _____ | <input type="radio"/> | <input type="radio"/> |
| 6. Have you had any teeth removed? _____ | <input type="radio"/> | <input type="radio"/> |

Smile Characteristics

| | | |
|--|-----------------------|-----------------------|
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="radio"/> | <input type="radio"/> |
| 8. Have you ever whitened (bleached) your teeth? _____ | <input type="radio"/> | <input type="radio"/> |
| 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="radio"/> | <input type="radio"/> |
| 10. Have you been disappointed with the appearance of previous dental work? _____ | <input type="radio"/> | <input type="radio"/> |

Bite and Jaw Joint

| | | |
|--|-----------------------|-----------------------|
| 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="radio"/> | <input type="radio"/> |
| 12. Do you / would you have any problems chewing gum? _____ | <input type="radio"/> | <input type="radio"/> |
| 13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ | <input type="radio"/> | <input type="radio"/> |
| 14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="radio"/> | <input type="radio"/> |
| 15. Are your teeth crowding or developing spaces? _____ | <input type="radio"/> | <input type="radio"/> |
| 16. Do you have to squeeze to make your teeth fit together or do you have more than one bite? _____ | <input type="radio"/> | <input type="radio"/> |
| 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="radio"/> | <input type="radio"/> |
| 18. Do you clench your teeth in the daytime or make them sore? _____ | <input type="radio"/> | <input type="radio"/> |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | <input type="radio"/> | <input type="radio"/> |
| 20. Do you wear or have you ever worn a bite appliance? _____ | <input type="radio"/> | <input type="radio"/> |

Tooth Structure

| | | |
|--|-----------------------|-----------------------|
| 21. Have you had any cavities within the past 3 years? _____ | <input type="radio"/> | <input type="radio"/> |
| 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="radio"/> | <input type="radio"/> |
| 23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="radio"/> | <input type="radio"/> |
| 24. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ | <input type="radio"/> | <input type="radio"/> |
| 25. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="radio"/> | <input type="radio"/> |
| 26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="radio"/> | <input type="radio"/> |
| 27. Do you get food caught between any teeth? _____ | <input type="radio"/> | <input type="radio"/> |

Gum and Bone

| | | |
|---|-----------------------|-----------------------|
| 28. Do your gums bleed when brushing or flossing? _____ | <input type="radio"/> | <input type="radio"/> |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="radio"/> | <input type="radio"/> |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="radio"/> | <input type="radio"/> |
| 31. Is there anyone with a history of periodontal disease in your family? _____ | <input type="radio"/> | <input type="radio"/> |
| 32. Have you ever experienced gum recession? _____ | <input type="radio"/> | <input type="radio"/> |
| 33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="radio"/> | <input type="radio"/> |
| 34. Have you experienced a burning sensation in your mouth? _____ | <input type="radio"/> | <input type="radio"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



Medical History

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

Patient Name _____ Nickname _____ Age _____

Name of Physician and their specialty _____ Phone Number _____

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

Please Answer:

- | | |
|---|--|
| 1. Hospitalization for illness or injury _____ <input type="radio"/> YES <input type="radio"/> NO | 26. Osteoporosis/ osteopenia (taking bisphosphonates) _____ <input type="radio"/> YES <input type="radio"/> NO |
| 2. An allergic reaction to _____ <input type="radio"/> YES <input type="radio"/> NO | 27. Arthritis _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> aspirin, ibuprofin, acetaminophen, codeine | 28. Glaucoma _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> penicilin | 29. Contact Lenses _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> erythromycin | 30. Head or neck injuries _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> tetracycline | 31. Epilepsy, convulsions (seizures) _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> sulpha | 32. Neurologic problems (attention deficit disorder) _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> local anesthetic | 33. Viral infections and cold sores _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> flouride | 34. Any lumps or swelling in the mouth _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> metals (nickel, gold, silver, _____) | 35. Hives, skin rash, hay fever _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> latex | 36. Venereal disease _____ <input type="radio"/> YES <input type="radio"/> NO |
| <input type="radio"/> other _____ | 37. Hepatitis (type _____) _____ <input type="radio"/> YES <input type="radio"/> NO |
| 3. Heart problems, or cardiac stent within the last 6 months _____ <input type="radio"/> YES <input type="radio"/> NO | 38. HIV / AIDS _____ <input type="radio"/> YES <input type="radio"/> NO |
| 4. History of infective endocarditis _____ <input type="radio"/> YES <input type="radio"/> NO | 39. Tumor, abnormal growth _____ <input type="radio"/> YES <input type="radio"/> NO |
| 5. Artificial heart valve, repaired heart defect (PFO) _____ <input type="radio"/> YES <input type="radio"/> NO | 40. Radiation therapy _____ <input type="radio"/> YES <input type="radio"/> NO |
| 6. Pacemaker or implantable defibulator _____ <input type="radio"/> YES <input type="radio"/> NO | 41. Chemotherapy _____ <input type="radio"/> YES <input type="radio"/> NO |
| 7. Artificial prosthesis (heart valve or joints) _____ <input type="radio"/> YES <input type="radio"/> NO | 42. Emotional problems _____ <input type="radio"/> YES <input type="radio"/> NO |
| 8. Rheumatic or scarlet fever _____ <input type="radio"/> YES <input type="radio"/> NO | 43. Psychiatric treatment _____ <input type="radio"/> YES <input type="radio"/> NO |
| 9. High or low blood pressure _____ <input type="radio"/> YES <input type="radio"/> NO | 44. Antidepressant medication _____ <input type="radio"/> YES <input type="radio"/> NO |
| 10. A stroke (taking blood thinners) _____ <input type="radio"/> YES <input type="radio"/> NO | 45. Alcohol / drug dependency _____ <input type="radio"/> YES <input type="radio"/> NO |
| 11. Anemia or other blood disorder _____ <input type="radio"/> YES <input type="radio"/> NO | ARE YOU: |
| 12. Prolonged bleeding due to a slight cut (INR >3.5) _____ <input type="radio"/> YES <input type="radio"/> NO | 46. Presently being treated for any other illness _____ <input type="radio"/> YES <input type="radio"/> NO |
| 13. Emphysema or sarcoidosis _____ <input type="radio"/> YES <input type="radio"/> NO | 47. Aware of a change in your general health _____ <input type="radio"/> YES <input type="radio"/> NO |
| 14. Tuberculosis _____ <input type="radio"/> YES <input type="radio"/> NO | 48. Taking medication for weight management (i.e. fen-phen) _____ <input type="radio"/> YES <input type="radio"/> NO |
| 15. Asthma _____ <input type="radio"/> YES <input type="radio"/> NO | 49. Taking dietary supplements _____ <input type="radio"/> YES <input type="radio"/> NO |
| 16. Breathing or sleeping problems (i.e. snoring, sinus) _____ <input type="radio"/> YES <input type="radio"/> NO | 50. Often exhausted or fatigued _____ <input type="radio"/> YES <input type="radio"/> NO |
| 17. Kidney disease _____ <input type="radio"/> YES <input type="radio"/> NO | 51. Subject to frequent headaches _____ <input type="radio"/> YES <input type="radio"/> NO |
| 18. Liver disease _____ <input type="radio"/> YES <input type="radio"/> NO | 52. A tobacco user _____ <input type="radio"/> YES <input type="radio"/> NO |
| 19. Jaundice _____ <input type="radio"/> YES <input type="radio"/> NO | 53. Considered a touchy or oversensitive person _____ <input type="radio"/> YES <input type="radio"/> NO |
| 20. Thyroid, parathyroid disease, or calcium deficiency _____ <input type="radio"/> YES <input type="radio"/> NO | 54. Often unhappy or depressed _____ <input type="radio"/> YES <input type="radio"/> NO |
| 21. Hormone deficiency _____ <input type="radio"/> YES <input type="radio"/> NO | 55. FEMALE - taking birth control pills _____ <input type="radio"/> YES <input type="radio"/> NO |
| 22. High cholesterol or taking statin drugs _____ <input type="radio"/> YES <input type="radio"/> NO | 56. FEMALE - pregnant _____ <input type="radio"/> YES <input type="radio"/> NO |
| 23. Diabetes (HbA1c= _____) _____ <input type="radio"/> YES <input type="radio"/> NO | 57. MALE - prostate disorders _____ <input type="radio"/> YES <input type="radio"/> NO |
| 24. Stomach or duodenal ulcer _____ <input type="radio"/> YES <input type="radio"/> NO | |
| 25. Digestive disorders (i.e. gastric reflux) _____ <input type="radio"/> YES <input type="radio"/> NO | |

Describe any current medical treatment, impending surgery or any other treatment that may possibly affect your dental treatment.

| Drug | Purpose | Drug | Purpose |
|-------|---------|-------|---------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Ask for additional sheet if you are taking more than 4 medications.

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



New Patient Form

PALMA SOLA SMILES

1906 59th St. W. Unit A, Bradenton, FL 34209

941.795.0144

First Name: _____ Last Name: _____ Middle Initial: _____

Date: _____ Whom may we thank for referring you? _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Birth Date: _____ Age: _____

Gender: Male Female Marital Status: Single Married Separated Divorced Widowed

Spouse / Parent: _____ Phone: _____

Occupation: _____

Employer: _____

Primary Insurance:

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Social Security: _____

Insured Birth Date: _____

Group Number: _____ Member ID: _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Secondary Insurance:

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Social Security: _____

Insured Birth Date: _____

Group Number: _____ Member ID: _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Medical Insurance:

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Social Security: _____

Insured Birth Date: _____

Group Number: _____ Member ID: _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Communication Preference

Text Message: _____

Email: _____

Phone Call: _____

Comments:



Patient Health Update

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

Patient Health Update

Date: _____

Health Changes: _____

Physician's Name: _____ Last Physical Exam: _____

Physician's Phone: _____ Allergies: _____

Patient's Signature: _____ Staff Initials: _____

Patient Health Update

Date: _____

Health Changes: _____

Physician's Name: _____ Last Physical Exam: _____

Physician's Phone: _____ Allergies: _____

Patient's Signature: _____ Staff Initials: _____

Patient Health Update

Date: _____

Health Changes: _____

Physician's Name: _____ Last Physical Exam: _____

Physician's Phone: _____ Allergies: _____

Patient's Signature: _____ Staff Initials: _____

Patient Health Update

Date: _____

Health Changes: _____

Physician's Name: _____ Last Physical Exam: _____

Physician's Phone: _____ Allergies: _____

Patient's Signature: _____ Staff Initials: _____



Personal Dental Needs Survey

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

Name: _____ Date: _____

These things are important to me about my dental health:

Former Dentist's Name: _____ City: _____

Please Circle One:

- My mouth is**
 - very comfortable.
 - moderately comfortable.
 - uncomfortable.
- I**
 - want to save my teeth at all costs.
 - prefer to keep my teeth if cost and time are reasonable.
 - expect to someday lose my teeth and have dentures.
- I**
 - have set goals to achieve optimum oral health with a previous dentist.
 - want to set goals to achieve optimum oral health.
 - am not very interested in setting personal goals to achieve optimum oral health.
- I**
 - have followed the recommendations for optimum dental health given by my dentist.
 - have not done what dentists recommended I do for my oral health.
 - usually only go to the dentist for emergencies.
- I think I**
 - have EXCELLENT oral health.
 - have GOOD oral health.
 - have POOR oral health.
- I desire**
 - excellent oral health.
 - average or good oral health.
 - crisis care only.

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care. (The most important would be #1)

| | |
|---|------------------------------|
| _____ Preventive Dental Health Care | _____ Cost and Affordability |
| _____ Excellence and Quality of Service | _____ Other _____ |
| _____ Freedom of Pain | _____ |

Please circle the level of fear you have about your dentist visits. (10 being the greatest fear)

1 2 3 4 5 6 7 8 9 10

- When discussing my treatment plan, I prefer:**
 - The Big Picture
 - Detail by Detail
- When evaluating my smile, it's most important:**
 - What I See
 - What Others See

What are some questions about dentistry and your oral health that you have never had adequately answered?

Signature: _____



Photography Consent Form

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

PALMA SOLA SMILES AUTHORIZATION FOR THE USE OF PHOTOGRAPHY TESTIMONIALS AND MARKETING INFORMATION

In connection with the healthcare services that I shall be receiving, I (patient's name) _____ do hereby authorize photography (using current and accepted methods) may be taken of me or parts of my body (as defined by my healthcare provider), under the following conditions:

1. My healthcare provider may take the photography or it may be taken by a designee approved by my healthcare provider who has signed a HIPAA required Business Associate Agreement with my healthcare provider.
2. The photography shall be used for medical records and if, in the judgement of my healthcare provider, medical research, education or science will be benefitted by its use, such photography and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge and research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name. I understand I may be recognized and identifiable in the photography. All reasonable efforts will be made to avoid personal identification.
3. I authorize my healthcare provider to use testimonials given by me, or photography taken of me, for marketing purposes. I understand this information may be posted on social media outlets, the providers' website or used as directed by my healthcare provider. This information will be used only in a professional and ethical manner as directed by my healthcare provider. I have the right to request that my health care provider inform me prior to using any information for marketing or non-healthcare related purposes.
4. I authorize my healthcare provider to send information to me, either electronically or through a mail service, about products or services the practice may now or in the future provide that may be of interest to me.
5. I understand I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization, or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, we must receive the revocation in writing. The revocation must include:
 - The patient's full name and address
 - The patient's desire to revoke this authorization
 - The effective date of this revocation
 - The patient's and/or patient's agent/representative's signature
 - The relationship to the patient, if applicable

** We will accept written revocations of this authorization by Certified U.S. mail only.

I fully understand and accept the terms of this authorization. _____

Signature:

Patient's Signature

Patient's Agents/ Representative's Signature & Relationship

Signature of Witness

Date



Privacy Practices

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

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

Our Legal Duty:

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make changes to this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information:

We use and disclose your health information for treatment, payment and health care operations. For example:

Treatment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and proven performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgement of whether the disclosure would be in your best interest. We may use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employees regarding work-related illness or injury;
- To report adult abuse, neglect or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;

- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;

- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and as
- Authorized by state worker's compensation laws.

Patient Rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may - but are not required to - prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide a satisfactory explanation of how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. 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 using the information listed at the end of this notice.

If you believe that:

- We may have violated your privacy rights.
- We made an incorrect decision about access to your health information.
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations.

You may contact us using the information listed below. You also may 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 the 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.

PALMA SOLA SMILES
 1906 59th St. W. Unit A
 Bradenton, Florida 34209
 941.795.0144
 www.palmasolasmiles.com

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____, have received a copy of the **Notice of Privacy Practices of this office.**
 (NAME, PLEASE PRINT)

| | |
|------------------------------|---------------|
| _____ Patient's Signature | _____ Date |
|------------------------------|---------------|

Please note: It is your right to refuse to sign this acknowledgement.

Office Use Only:

We tried to obtain written acknowledgement by the individual noted above receipt of our Notice of Privacy Practices, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgements.
- A communication barrier prevented us from obtaining acknowledgement
- The individual was unwilling to sign.
- Other: _____



Sleep Screening Questionnaire

PALMA SOLA SMILES
1906 59th St. W. Unit A, Bradenton, FL 34209
941.795.0144

Patient Name: _____ Date: _____

Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would Never Doze

1 = Slight Chance of Dozing

2 = Moderate Chance of Dozing

3 = High Chance of Dozing

| | | | |
|---|-------|---|-------|
| Sitting and Reading | _____ | Lying Down to Rest in a Afternoon | _____ |
| Watching Television | _____ | Sitting and Talking to Someone | _____ |
| Sitting Inactive In a Public Place (i.e. Theater) | _____ | Sitting Quietly After Lunch Without Alcohol | _____ |
| As a Passenger for an Hour Without a Break | _____ | In a Car, While Stopping for a Few Minutes in Traffic | _____ |

TOTAL SCORE _____

A SCORE OF 8 OR GREATER INDICATES THE POSSIBILITY OF SLEEP DISORDERED BREATHING.

Thornton Snoring Scale

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner.)

0 = Never

1 = Infrequently (1 night per week)

2 = Frequently (2-3 nights per week)

3 = Most of the Time (4 or more nights per week)

| | |
|---|-------|
| My Snoring Affects My Relationship with My Partner | _____ |
| My Snoring Causes My Partner to be Irritable or Tired | _____ |
| My Snoring Requires Us to Sleep in Separate Rooms | _____ |
| My Snoring is Loud | _____ |
| My Snoring Affects People When I am Sleeping Away From Home (i.e. hotel, camping, etc.) | _____ |

TOTAL SCORE _____

A SCORE OF 5 OR GREATER INDICATES YOUR SNORING MAY BE SIGNIFICANTLY AFFECTING YOUR QUALITY OF LIFE.