MACK E. COKER, DDS, MS
DANIEL K. HO, DMD, DMSc, MSc

Diplomates of the American Board of Periodontology
13303 Champion Forest Drive, Bldg. 3, Houston, TX 77069
Tel: 281-444-4704 Fax: 281-444-7465
Periodontics, Dental Implants & Laser Technology

NAME: _____ DATE: _____

ADDRESS: _____
STREET CITY STATE ZIP

SSN: _____ HOME PHONE: (____) _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____ EMAIL: _____

SINGLE: _____ MARRIED: _____ DIVORCED: _____ WIDOWED: _____ CHILD: _____

EMPLOYER: _____ OFFICE PHONE: (____) _____

POSITION: _____ #YRS: _____ CELL PHONE: (____) _____

SPOUSE/PARENT: _____ PHONE: (____) _____

RESPONSIBLE PARTY: _____ PHONE: (____) _____

*I UNDERSTAND THAT ALL FEES INCURRED WILL BE MY RESPONSIBILITY: _____
SIGNATURE

REFERRED TO THIS OFFICE BY:

FAMILY DENTIST: _____ LOCATION: _____ PH #: _____

FAMILY PHYSICIAN: _____ LOCATION: _____ PH #: _____

Are you experiencing pain in your mouth now	YES	NO
Have you had previous periodontal (gum) care	YES	NO
Do you have your teeth cleaned on a regular basis	YES	NO
Do you brush your teeth regularly (2-3 times per day)	YES	NO
Have I treated your friends or family	YES	NO
Do you smoke	YES	NO
Have you ever smoked	YES	NO

BRIEFLY OUTLINE WHAT YOU MIGHT HAVE FOR:

BREAKFAST: _____ ALCOHOL INTAKE: Drinks/Day: _____

LUNCH: _____ COFFEE/Day: Reg. _____ Decaf _____

DINNER: _____ SOFT DRINKS/Day: _____

DAILY EXERCISE: _____ HOURS OF SLEEP/Night: _____

Have you had swollen areas of the gums	YES	NO
Do your gums bleed	YES	NO
Have yo unoticed any loose teeth	YES	NO
Have you noticed any bad odors or tastes	YES	NO
Are your teeth sensitive to hot, cold, or sweets	YES	NO
Have your front teeth separated, causing spaces	YES	NO
Do you floss or use gum stimulators on a daily basis	YES	NO
Have you ever worn braces to straighten your teeth	YES	NO
Would you be disturbed if you had to wear false teeth	YES	NO
Are you aware of any clenching/griding of teeth at night	YES	NO
Do you have headaches on a regular basis	YES	NO
Have you ever had a frightening experience with dentistry	YES	NO

PLEASE CHECK ANY OF THE FOLLOWING YOU EVER HAD:

_____ Allergies to drugs
_____ AIDS
_____ AIDS Related Complex
_____ HIV Antibody Positive
_____ Asthma
_____ High Blood Pressure
_____ Cancer
_____ Cardiac Problems
_____ Chest Pains
_____ Shortness of Breath
_____ Heart Attack
_____ Stroke
_____ Cold Sores
_____ Fever Blisters
_____ Chronic Cough
_____ Diabetes
_____ Epilepsy
_____ Excessive Bleeding
_____ Fainting
_____ Frequent Thirst
_____ Gonorrhea
_____ Hay Fever
_____ Hepatitis
_____ Herpes (Mouth)
_____ Herpes (Genital)
_____ Hives Rash
_____ Jaundice
_____ Kidney Disease
_____ Liver Disease
_____ Mitral Valve Prolapse
_____ Mononucleosis
_____ Pneumonia
_____ Psychiatric Treatmetn
_____ Radiation Treatment
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Seizures
_____ Sinus Problems
_____ Syphilis
_____ Thrush
_____ Trench Mouth
_____ Tuberculosis
_____ Tonsils Removed
_____ Sudden Weight Loss

ARE YOU OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING DRUGS:

Cortisone Drugs, Steroids or ACTH..... YES NO
Anticoagulants or Blood Thinners..... YES NO
Tranquilizers or Sedatives..... YES NO
Do you have any blood disorders such as anemia..... YES NO
Please list any medications you are currently taking: YES NO

ALLERGIES:

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSELY TO:

Local Anesthetics..... YES NO
Penicillin or other antibiotics..... YES NO
Sulfa drugs..... YES NO
Barbiturates..... YES NO
Aspirin..... YES NO
Iodine..... YES NO
Codeine or other narcotics..... YES NO
OTHER..... YES NO
Do you take an antibiotic prior to any dental or medical treatment..... YES NO

PARENTS HISTORY:

Mother:	Teeth Present	Gum Disease	Dentures
Father:	Teeth Present	Gum Disease	Dentures

WOMEN ONLY:

Are you pregnant?_____
No. of children:_____
Birth weights:_____

WHAT IS THE CHIEF COMPLAINT ABOUT YOUR MOUTH OR TEETH? _____

FOR OFFICE USE ONLY

PRE-MED_____ ACHROMYCIN _____
NaBUTISOL_____ VICODEN_____
DEMEROL_____ OTHER_____
PHENERGAN_____ MEDICAL CONSULT_____
N_2O_2 _____
OTHER_____

Acknowledgement of Treatment & Fees

North Houston Periodontics & Dental Implants
Mack E Coker, DDS, MS | Daniel K Ho, DMD, DMSc, MSc
13303 Champion Forest Drive, Building 3, Houston, TX 77069

Treatment Options: I acknowledge that all treatment options for my dental condition have been fully explained to me. It is my responsibility to complete treatment and follow the recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed or appointments are missed, adverse results could affect my dental health.

Treatment Fees: Fees are **estimates** only. They are valid for 90 days from the date above and are subject to revision. Treatment could be altered if your dental needs change. However, you will be notified of any change(s) in your treatment.

Dental Insurance: For our patients with dental insurance, we are pleased with the care that you have selected. Your insurance is a contract between you and your insurance company. Our professional services are rendered to you and not your insurance company. Therefore, you are **directly responsible** for the obligation of payment for treatment. We will help you to submit claim(s) to your insurance company after the treatment is done. We can also help you to find out **ROUGHLY** what your insurance may cover on the proposed treatment. However, what we obtain from insurance company in terms of their coverage is just an **estimate** which is subject to change basing on many factors such as your annual remaining benefits, pre-existing conditions and exclusions, deductibles, etc. You as the patient is ultimately responsible for the full payment of the treatment. In addition, sometimes your insurance may deem a treatment "not necessary" and therefore insurance does not pay for the treatment. The person who decides what treatment is deemed "necessary" for you is NOT your insurance company but your dentist, as such you are responsible for the cost of the treatment even if your insurance company deems treatment not necessary.

I have reviewed, understood and agreed to abide by the information and rules mentioned in this "Acknowledgement of Treatment & Fees form"

Patient Name: _____ Witness Name: _____

Patient Signature: _____ Witness Signature: _____

Date: _____ Date: _____

APPOINTMENT CANCELLATION POLICY AGREEMENT

North Houston Periodontics & Dental Implants
Mack E Coker, DDS, MS | Daniel K Ho, DMD, DMSc, MSc
13303 Champion Forest Drive, Building 3, Houston, TX 77069

Our practice firmly believes that good doctor-patient relationship is based upon good communication. Please call us at (281) 444-4704 **no less than 48 BUSINESS hours** prior to your scheduled appointment to notify us of any changes or cancellations. **Your dental appointment is considered confirmed at the time of booking.** If you need to alter a Monday appointment, please contact us by Thursday the prior week.

Hygiene appointments (dental cleaning) that are cancelled with less than 48 hours notification will be subject to a **$40.00** fee.

Procedure appointments (surgery or other dental treatments) that are cancelled with less than 48 hours notification will be subject to a **$100.00** fee.

Patients with NO SHOW to hygiene appointments (dental cleaning) will be subject to a **$50.00** fee.

Patients with NO-SHOW to procedure appointments (surgery or other dental treatments) will be subject to a **$180.00** fee.

Patients who do not show up for their appointment without notifying us to cancel the appointment will be considered as **NO SHOW**.

If you need to cancel your appointment and cannot reach our office after business hours or on weekends or cannot get through our office telephone line, please call or text Dr. Daniel Ho to cancel appointments at any time 24 hours a day 7 days a week on his cell phone number 617-407-3525.

We understand that under special situations you will need to cancel your appointment less than 48 hours before your appointment. Cancellation fees in these situations may be waived or reduced but only with management approval.

I have read the **Appointment Cancellation Policy** and agree to the terms outlined above.

[Patient Signature]	[Patient Name]	Date
[Witness Signature]	[Witness Name]	Date

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, iin contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have effected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in public place (like a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Analyze Your Score

Interpretation:	
From 0-7	It is unlikely that you are abnormally sleepy
From 8-9	You have an average amount of daytime sleepiness
From 10-15	You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention
From 16-20	You are excessively sleep and should consider seeking medical attention

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Photography & Video Release Form

I/We hereby irrevocably grant North Houston Periodontics & Dental Implants permission to use, publish, copyright, and/or reproduce in any form all photographs, videos or statements made of me this day and throughout the course of treatment, without further compensation to me. All images shall be considered the property of North Houston Periodontics & Dental Implants solely and completely.

I am at least 18 years of age and am competent to contract in my own name (circle one): **Yes** **No**
(If under 18, a parent or guardian must sign the appropriate section below.)

[Patient Signature]	[Patient Name]	Date
[Parent or Guardian Signature, if under 18]	[Parent or Guardian Name, if under 18]	Date
[Witness Signature]	[Witness Name]	Date

NOTICE OF PRIVACY PRACTICES

North Houston Periodontics & Dental Implants
Mack E Coker, DDS, MS | Daniel K Ho, DMD, DMSc, MSc 13303 Champion Forest Drive, Building 3, Houston, TX 77069

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers of specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions or certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 25, 2016 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to a file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a compliant or more information about our Privacy Practices, please contact:

North Houston Periodontics & Dental Implants, Daniel K. Ho
13303 Champion Forest Drive, Building 3, Houston, TX 77069
281-444-4704

The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue S.W., Washington, D.C. 20201
877-696-6775 (toll-free)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the **Notice of Privacy Practices** of this office.

[Signature of patient, parent or guardian] [Printed name of patient, parent or guardian] Date

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

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