Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

2960 Professional Park Drive, Burlington, NC 27215
(336) 228-8159 office • (336) 226-1936 fax
www.alamancefamilydentistry.com • info@alamancefamilydentistry.com

Name: _____ Preferred Name: _____
Last First MI

Assigned Gender at Birth ☐ male ☐ female

Address: _____ City _____ State _____ Zip _____

SSN: _____ DOB: _____

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

Preferred method of contact: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: o Single o Married o Divorced o Widowed o Separated o Domestic Partner

How did you hear about our office? _____

■ **Medical** Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ **Medical** Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ **Dental** Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ **Dental** Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ **Release**

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient or Parent/Guardian Signature: _____

Medical History

Primary Care Physician: _____ Phone #: _____

Sleep Physician (if applicable): _____ Phone #: _____

Current Dentist: _____ Phone #:_____

Approximate date of last dental visit? _____

Do you use tobacco in any form? o Yes o No

Are you taking any medications? o Yes o No **(you may attach a sheet of medications to this)**
If "Yes," please list names of medications and problems for which they are taken:

1) _____ taken for _____ 5) _____ taken for _____
2) _____ taken for _____ 6) _____ taken for _____
3) _____ taken for _____ 7) _____ taken for _____
4) _____ taken for _____ 8) _____ taken for _____

Have you had any surgical procedures? o Yes o No
If "Yes," please list each one: _____

_____

- Please check if you have any of the below conditions -

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
o	o	**History of stroke**	o	o	Difficulty breathing	o	o	Mitral valve prolapse
o	o	**Hypertension** (high blood pressure)	o	o	Drug Abuse	o	o	Organ transplant
			o	o	Dry mouth	o	o	Osteoporosis
o	o	**Type 2 diabetes**	o	o	Eating disorder	o	o	Pacemaker
o	o	**Heart disease**	o	o	Emphysema	o	o	Radiation therapy
o	o	**Mood disorder** (eg. anxiety /depression)	o	o	Epilepsy	o	o	Rheumatic fever
			o	o	Fainting spells	o	o	Seizures
o	o	**Insomnia**	o	o	Fever blisters	o	o	Sexually Transmitted Disease
o	o	**Impaired cognition**	o	o	Frequent headaches	o	o	Shingles
o	o	Abnormal bleeding	o	o	Glaucoma	o	o	Sickle Cell Disease
o	o	Acid reflux	o	o	Heart arrhythmia	o	o	Sinus problems
o	o	Alcohol abuse	o	o	Heart attack	o	o	Thyroid problems
o	o	Anemia	o	o	Heart murmur	o	o	Type I diabetes
o	o	Angina pectoris	o	o	Heart surgery	o	o	Tuberculosis
o	o	Arthritis	o	o	Hemophilia	o	o	Ulcers
o	o	Artificial heart valve	o	o	Hepatitis	o	o	Other _____
o	o	Asthma or hay fever	o	o	Joint replacement			
o	o	Cancer	o	o	Kidney disease			
o	o	Chemotherapy	o	o	Liver disease			
o	o	Congenital heart defect						

Do you require antibiotics before dental treatment? o Yes o No

If "Yes", for what condition? _____

Are you allergic to any of the following?

Yes	No	
o	o	Penicillin
o	o	Codeine
o	o	Amoxicillin
o	o	Dental Anesthetics
o	o	Acrylic
o	o	Jewelry
o	o	Latex
o	o	Metals (gold, nickel, etc.) list: _____
o	o	Aspirin
o	o	Tetracycline
o	o	Sulfa Drugs
o	o	Iodine

Please list any other allergies: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Phone number: _____

The information I have given is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in medical status.

Signature: _____ Date: _____

Photography Release

I _____, hereby authorize Emily L. Dornblazer, DMD, PA to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Signature Date

Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

Authorization for Release of Information

Name: _____ DOB: _____
Last First MI

I authorize Emily L. Dornblazer, DMD, PA or any member of her office to release protected health information about the above named patient in the following manner and to the identified person(s).

Entity to Receive Information **Check each person/entity that you approve to receive information**	**Description of Information to be released.** Check what type of information can be given to person/entity.
☐ **Voice Mail**	☐ Appointment Reminders ☐ Results of lab tests/x-rays
☐ **E-mail communication** **Email address:** _____	☐ Appointment Reminders ☐ General Office Information
☐ **Text Message**	☐ Appointment Reminders
☐ **Work**	☐ Appointment Reminders ☐ General Office Information
☐ **Person 1** **Name:** _____	☐ Financial Information ☐ Medical Information
☐ **Person 2** **Name:** _____	☐ Financial Information ☐ Medical Information

Patient Rights

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protect health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and my treatment is not conditional upon signing.

The Information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____
Patient Signature **Date**

Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

Acknowledgement of Receipt of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices of Emily L. Dornblazer, DMD, PA and, if requested, have been given a copy.

_____ _____
Signature of Patient Date

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

☐ An emergency existed & a signature was not possible at the time

☐ The individual refused to sign

☐ A copy was mailed with a request for a signature by return mail

☐ Unable to communicate with the patient for the following reason:

_____

☐ Other: _____

Prepared by: _____

Signature: _____

Date: _____

Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

Practice Policies

Name: _____ Date of birth: _____
Last First Middle Initial

We believe that you deserve the best care, that is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of patients. Some have dental benefits but some do not. Here are some important things you should know:

Initial

_____ • Our office provides treatment **estimates** as a **courtesy.** Your insurance benefits are a contract between **you** and **your insurance company/employer**. It is ***entirely your responsibility*** to understand and track your benefits, not ours. Dental benefits will never completely pay for your dental care. Dental benefits are only meant to assist you.

_____ • We work with hundreds of insurance companies. Although we can maintain computerized histories of payment given by an insurance company, they change frequently; therefore, **it is impossible to give you a guaranteed quote at the time of service**. We estimate your portion based on the most up-to-date information we have, but it is **only an estimate**. We are happy to file a "pre-treatment authorization" with your insurance company prior to treatment. However, keep in mind that this ***is not a guarantee of coverage***. This does delay treatment but will give you a more accurate out of pocket figure.

_____ • We will bill your insurance company as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize the insurance you have is a *legal contract between YOU and your insurance company*. Our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Unpaid balances over 30 days will be due immediately or considered a delinquent account to be handled by our collections manager, and a *$35 collection fee* will be charged to your account.

_____ • We require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash and checks (for existing patients with established payment history). **We do not accept checks for over $500 for any patient**. If you are in need of an extended finance option, we also work with CareCredit. CareCredit offers 6, 12, 18 and 24 months "same as cash" or longer terms with an interest bearing, revolving charge designed to meet your treatment needs on approved credit.

_____ • A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. **If you fail to keep your scheduled appointment, or do not provide at least 24 hours notice to reschedule or cancel, you will incur a $50 cancellation fee, and a deposit may be required to schedule a future appointment.** This deposit will be applied to your treatment as long as you abide by the cancellation policy stated previously. Should you again miss your appointment, or provide less than 24 hours notice to reschedule or cancel the appointment, this deposit will be charged to your account. Please keep in mind that insurance does not cover cancellation fees.

_____ • There is a **$35.00 fee for any returned check.**

_____ • In the event of an emergency after regular hours, a $75 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice, will be charged a $125 after hours emergency fee.

If you have any questions about our Office Policies, please do not hesitate to ask.

I agree to comply with the Office Policies stated above.

Print Name: _____ Date: _____

Patient/Parent (Guardian) Signature: _____

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Epworth Sleepiness Scale

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

What is the chance of you falling asleep when sitting and reading?

0 1 2 3

What is the chance of you falling asleep when watching TV?

0 1 2 3

What is the chance of you falling asleep when sitting inactive in a public place (e.g. a theater or a meeting)?

0 1 2 3

What is the chance of you falling asleep as a passenger in a car for an hour?

0 1 2 3

What is the chance of you falling asleep when lying down to rest in the afternoon when circumstances permit?

0 1 2 3

What is the chance of you falling asleep when sitting and talking to someone?

0 1 2 3

What is the chance of you falling asleep when sitting quietly after a lunch without alcohol?

0 1 2 3

What is the chance of you falling asleep when in a car, while stopped for a few minutes in traffic?

0 1 2 3

Total Score: _____

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Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (ie. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not noticeable at all	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED / DISTRESSED are you about your current sleep problem?

Not worried at all	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring / Interpretation:
Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ your total score

Total score categories:
0 – 7: No clinically significant insomnia
8 – 14: Subthreshold insomnia
15 – 21: Clinical insomnia (moderate severity)
22 – 28: Clinical insomnia (severe)

Diagnostic Criteria for Temporomandibular Disorders
Symptom Questionnaire

Patient name _____Date _____

PAIN

1. Have you ever had pain in your jaw, temple, in the ear, or in front of the ear on either side? **No** ☐ **Yes** ☐

If you answered NO, then skip to Question 5.

2. How many years or months ago did your pain in the jaw, temple, in the ear, or in front of the ear first begin? _____years _____months

3. In the last 30 days, which of the following best describes any pain in your jaw, temple, in the ear, or in front of the ear on either side?

Select ONE response.

- ☐ No pain
- ☐ Pain comes and goes
- ☐ Pain is always present

If you answered NO to Question 3, then skip to Question 5.

4. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw, temple, in the ear, or in front of the ear on either side?

		No	Yes
A.	Chewing hard or tough food	☐	☐
B.	Opening your mouth, or moving your jaw forward or to the side	☐	☐
C.	Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum	☐	☐
D.	Other jaw activities such as talking, kissing, or yawning	☐	☐

HEADACHE

5. In the last 30 days, have you had any headaches that included the temple areas of your head? **No** ☐ **Yes** ☐

If you answered NO to Question 5, then skip to Question 8.

6. How many years or months ago did your temple headache first begin? _____years _____months

7. In the last 30 days, did the following activities change any headache (that is, make it better or make it worse) in your temple area on either side?

		No	Yes
A.	Chewing hard or tough food	☐	☐
B.	Opening your mouth, or moving your jaw forward or to the side	☐	☐
C.	Jaw habits such as holding teeth together, clenching/grinding, or chewing gum	☐	☐
D.	Other jaw activities such as talking, kissing, or yawning	☐	☐

JAW JOINT NOISES

		No	Yes	Office use R	L	DNK
8.	In the last 30 days, have you had any jaw joint noise(s) when you moved or used your jaw?	☐	☐	☐	☐	☐

CLOSED LOCKING OF THE JAW

9.	Have you ever had your jaw lock or catch, even for a moment, so that it would not open ALL THE WAY? **If you answered NO to Question 9 then skip to Question 13.**	☐	☐	☐	☐	☐
10.	Was your jaw lock or catch severe enough to limit your jaw opening and interfere with your ability to eat?	☐	☐	☐	☐	☐
11.	In the last 30 days, did your jaw lock so you could not open ALL THE WAY, even for a moment, and then unlock so you could open ALL THE WAY? **If you answered NO to Question 11 then skip to Question 13.**	☐	☐	☐	☐	☐
12.	Is your jaw currently locked or limited so that your jaw will not open ALL THE WAY?	☐	☐	☐	☐	☐

OPEN LOCKING OF THE JAW

13.	In the last 30 days, when you opened your mouth wide, did your jaw lock or catch even for a moment such that you could not close it from this wide open position? **If you answered NO to Question 13 then you are finished.**	☐	☐	☐	☐	☐
14.	In the last 30 days, when you jaw locked or caught wide open, did you have to do something to get it to close including resting, moving, pushing, or maneuvering it?	☐	☐	☐	☐	☐

The Oral Behavior Checklist

How often do you do each of the following activities, based on **the last month**? If the frequency of the activity varies, choose the higher option. Please place a (√) response for each item and do not skip any items.

	Activities During Sleep	None of the time	< 1 Night /Month	1-3 Nights /Month	1-3 Nights /Week	4-7 Nights/ Week
1	Clench or grind teeth **when asleep**, based on any information you may have	☐	☐	☐	☐	☐
2	Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	☐	☐	☐	☐	☐
	Activities During Waking Hours	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
3	Grind teeth together **during waking hours**	☐	☐	☐	☐	☐
4	Clench teeth together **during waking hours**	☐	☐	☐	☐	☐
5	Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)	☐	☐	☐	☐	☐
6	Hold, tighten, or tense muscles without clenching or bringing teeth together	☐	☐	☐	☐	☐
7	Hold or jut jaw forward or to the side	☐	☐	☐	☐	☐
8	Press tongue forcibly against teeth	☐	☐	☐	☐	☐
9	Place tongue between teeth	☐	☐	☐	☐	☐
10	Bite, chew, or play with your tongue, cheeks or lips	☐	☐	☐	☐	☐
11	Hold jaw in rigid or tense position, such as to brace or protect the jaw	☐	☐	☐	☐	☐
12	Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc	☐	☐	☐	☐	☐
13	Use chewing gum	☐	☐	☐	☐	☐
14	Play musical instrument that involves use of mouth or jaw (for example, woodwind, brass, string instruments)	☐	☐	☐	☐	☐
15	Lean with your hand on the jaw, such as cupping or resting the chin in the hand	☐	☐	☐	☐	☐
16	Chew food on one side only	☐	☐	☐	☐	☐
17	Eating between meals (that is, food that requires chewing)	☐	☐	☐	☐	☐
18	Sustained talking (for example, teaching, sales, customer service)	☐	☐	☐	☐	☐
19	Singing	☐	☐	☐	☐	☐
20	Yawning	☐	☐	☐	☐	☐
21	Hold telephone between your head and shoulders	☐	☐	☐	☐	☐

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Dental Patient Rights Statement

Alamance Family Dentistry is the best source of information about your oral appliance therapy. We want you to feel comfortable about your care. As an informed patient, you should know what you can expect from your dentist and understand your role in oral appliance therapy. The rights listed below do not establish legal entitlements or new standards of care but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship for oral appliance therapy.

Patient Rights

1. You have the right to choose your own qualified dentist and schedule an appointment in a timely manner.
2. You have the right to know the education and training of your qualified dentist and the dental care team.
3. You have the right to arrange to see the dentist every time you receive treatment, subject to any state law exceptions.
4. You have the right to adequate time to ask questions and receive answers regarding your condition and treatment plan for your oral appliance therapy.
5. You have the right to know what the qualified dentist thinks the optimal treatment plan is as well as the right to ask for alternative treatment options.
6. You have the right to an explanation of the purpose, probable (short-term and long-term) results, alternatives, and risks involved before consenting to a proposed treatment plan.
7. You have the right to be informed of continuing health care needs.
8. You have the right to know in advance the expected cost of treatment.
9. You have the right to accept, defer, or decline any part of your treatment recommendations.
10. You have the right to reasonable arrangements for care and emergency treatment.
11. You have the right to receive considerate, respectful, and confidential treatment at Alamance Family Dentistry, regardless of:
    - Race
    - Creed
    - National Origin
    - Gender
    - Ethnicity
    - Sex
    - Age
    - Disability
    - Diagnosis
    - Religious Affiliation
12. You have the right to expect Alamance Family Dentistry to use appropriate infection and sterilization controls.
13. You have the right to inquire about the availability of processes to mediate disputes about your treatment.

I have read this statement and understand my rights as a patient of this practice.

Name (printed): _____

Signature: _____ Date: _____

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INFORMED CONSENT FOR THE TREATMENT OF SLEEP-RELATED BREATHING DISORDERS WITH ORAL APPLIANCE THERAPY

You have been diagnosed by your Physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase your risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy (OAT) utilizes a custom-made, adjustable, FDA cleared appliance specifically made to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. In order to derive the benefits of OAT, the oral appliance must always be worn when you sleep.

Benefits of Oral Appliance Therapy

OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different, and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder. Additionally, durable medical equipment such as your oral appliance requires specific homecare, maintenance and periodic replacement.

Possible Risks, Side-Effects and Complications of Oral Appliance Therapy

With an oral appliance, some patients experience excessive drooling, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. It is possible to experience dislodgement of dental restorations, such as fillings, crowns and dentures. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once OAT is discontinued. These changes are likely to continue to worsen with continued use of the device.

It is mandatory for you to complete follow-up visits with Dr. Dornblazer to ensure proper fit and optimal positioning. If unusual symptoms or discomfort occur or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further. Follow-up assessments are necessary to assess your health and monitor your progress.

Once your oral appliance is in an optimal position, a post-adjustment assessment by your Physician is necessary to verify that the oral appliance is providing effective treatment.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include positive airway pressure (PAP) therapy, various surgical and implant procedures, and positional therapy (which prevents patients from sleeping on their back instead on their side). The risks and benefits of these alternative treatments should be discussed with your Physician who diagnosed your condition and prescribed treatment.

It is your decision to choose OAT alone or in combination with other treatments to treat your sleep-related breathing disorder. However, none of these may be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this office (address below), or to your Physician. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications and/or accidental injury.

Patient's Privacy and Confidentiality

I acknowledge receipt of the office's privacy policies. This includes a summary of the HIPAA federal law and the applicable state laws.

Patient Obligations and Acknowledgements

1. I understand the explanation of the proposed treatment. Further additional communication tools such as videos, pamphlets or articles may be available at my request.
2. I have read this document in its entirety and have had an opportunity to ask questions. Each of my questions has been answered to my satisfaction. If I do not understand this document, I have been offered this document in a different language or have been offered a language interpreter. My family alone is not acceptable to be my interpreter.
3. I agree that regularly scheduled follow-up appointments with Dr. Dornblazer are essential. These visits will attempt to minimize potential side effects and to maximize the likelihood of management of my OSA.
4. I understand that I must schedule a post-adjustment assessment with my Physician to verify that the oral appliance is providing effective treatment.
5. I will notify this office of any changes to the OAT, my teeth and my medical condition(s).
6. I understand that I must maintain my oral appliance through regularly scheduled follow-up appointments with my general dentist and Dr. Dornblazer, if not the same.
7. I understand that if I discontinue OAT, I agree to inform and follow up with my Physician and Dr. Dornblazer.
8. I understand that refusing to participate and cooperate as stated herein will put my health at risk.
9. I consent to treatment with a custom-made, adjustable, FDA cleared oral appliance to be delivered and adjusted by Dr. Dornblazer. I agree to follow all post-delivery and homecare instructions

Please sign and date this form below to confirm your agreement with the above statements. You will receive a copy of this document for your records, and it will be included in your patient records.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

If patient is a minor, please sign as Parent or Legal Guardian

_____ _____

Parent/Guardian's Signature Date

_____

Parent/Guardian's Printed Name

_____ _____

Witness's Signature Date

_____

Witness's Printed Name

Dentist's Acknowledgement

_____ _____

Emily L. Dornblazer, DMD Date

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