VACA & KIRBY DENTAL

CARING FOR YOU & YOUR SMILE

Welcome to Vaca and Kirby Dental. We are so honored you have chosen our dental team to take care of you and your smile! We envision dentistry as a critical way in which we are improving the oral health and overall health of the patient. We want you to know what you can expect from us at your initial appointment.

- You will be greeted by our front staff and your patient paperwork reviewed.
- A member of our clinical team will then take you to the appropriate operatory. Depending on your scheduled appointment, time is allowed to discuss your needs, take necessary digital photographs for proper diagnoses with our state-of-the-art equipment and proceed with the appointment. Whether this appointment is with our hygienist or as an emergency, we will provide you with a service level that exceeds your expectation.
- After an exam by either Dr. Vaca or Dr. Kirby, your needs and what is important to you will be discussed. We believe that your dental care begins with our relationship.
- A treatment plan, if needed, will be designed specifically for you by the doctor, and fully explained by the treatment coordinator.
- At checkout, we will collect payment for your service, reconfirm your insurance or discuss other payment options through Care Credit and Lending Club, if needed.

Our team strives to deliver the highest quality service to you in a comfortable and tranquil setting. We want to make sure you are pleased with your visit. Please take the time to write us a **Google** or **Facebook** review. We take patient satisfaction seriously and value your opinion. Referrals are the greatest compliment you can provide.

YOUR COMMITMENT TO YOUR DENTAL HEALTH

- You MUST visit our office a minimum of 2 times per calendar year for professional cleanings, evaluation of restorations and oral cancer screenings.
- If periodontal disease treatments are recommended, 4 Periodontal Maintenance cleanings per calendar year are required.
- Complete all recommended treatment in the quadrant within a timely period, in our office, as gum infection and bacterial decay can spread quickly from tooth to tooth
- Patients with certain systemic diseases or complications, taking chemotherapy or radiation, or certain medications causing dry mouth may invalidate warranty.

Date: _____ Signature: _____

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SLEEPwell LONGVIEW

DENTAL HISTORY

PLEASE CHECK THE FOLLOWING:	YES	NO
Sensitivity (hot, cold, sweet)	☐	☐
Where? UR LR UL LL		
Loose, chipped or shifting teeth	☐	☐
Mouth ulcers or cold sores	☐	☐
Teeth or fillings breaking	☐	☐
Grinding or clenching teeth	☐	☐
Bleeding, swollen or irritated gums	☐	☐
Do you struggle to find a natural bite?	☐	☐
Headaches, ear aches, neck aches or jaw joint pain	☐	☐
Bad breath	☐	☐
Lumps or swelling in your mouth	☐	☐
Sleep disorders	☐	☐
Apnea Sinus Snoring		

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?		
Sleep Apnea / Sleep Study	☐	☐
Braces	☐	☐
Gum recession	☐	☐
Gum treatments	☐	☐
Dentures or partial dentures	☐	☐
Any cavities within the past 3 years	☐	☐
Do you have a dry mouth or difficulty swallowing?	☐	☐
Do you have a bite appliance?	☐	☐
Grooves or notches at the gum line?	☐	☐

	YES	NO
Do you smoke, use chewing tobacco or vape?	☐	☐
How much?_____ For how long?_____		

IF I COULD CHANGE MY SMILE, I WOULD:		
Make my teeth whiter	☐	☐
Make my teeth straighter	☐	☐
Close spaces	☐	☐
Replace metal fillings with tooth colored restorations	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Replace old crowns that don't match	☐	☐
Have a smile makeover	☐	☐

If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐

ON A SCALE OF 1 – 10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Name of Previous Dentist: _____

City _____ State_____

Why did you leave your previous dentist? _____

Have you had an unfavorable dental experience?_____

What is the most important thing to you about your dental visit today? _____

_____

What is the most important thing to you about your future smile and dental health? _____

_____

On a scale of 1 – 10 where would you rate your fear of dental treatment: 1 2 3 4 5 6 7 8 9 10

Patient Signature (or Parent of Child) Date Dentist's Signature

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THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight questions in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How sleepy are you?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and Reading	•
Watching TV	•
Sitting inactive in a public place (e.g., 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	•

INTERPRETATION:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

Patient:_____ Date:_____

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FINANCIAL POLICY

Our philosophy in serving people is to be informative, honest and forthright. Clear communication concerning financial arrangements is necessary for a healthy relationship. This Policy is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Policy, please do not hesitate to ask our business office staff.

PAYMENT POLICY

- Full payment is due at the time of service.
- We accept Cash, Checks, Debit cards, MasterCard, Visa, American Express and Discover
- For those who qualify, we also accept Care Credit which offers no interest financing for up to twelve months.
- We also offer financing through Lending Club with extended payment plans.

DENTAL INSURANCE

As a courtesy, we will gladly file your claims and accept assignment of dental insurance benefits. Your policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract.

You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which can vary from one company to another.

Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits as well as amounts, limitations, exclusions, waiting periods, etc. is YOUR responsibility. We will assist in that understanding, but receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

After dental insurance has paid its portion, a statement is sent for the remaining balance, which is due upon receipt. Initial ____

RETURNED CHECKS/UNPAID BALANCES

Vaca and Kirby Dental charges $35 for returned checks. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%. Initial ____

MISSED APPOINTMENTS

We feel our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared and all is made ready for your appointment. In order to be respectful of other patient's needs, a missed appointment will be subject to a $50 cancellation fee. That fee is waived with 24 hour notice during OUR REGULAR business hours. Initial ____

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY

DATE: _____ SIGNATURE: _____

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MEDICAL HISTORY

Y	N	
☐	☐	Allergies (Seasonal) ADD or ADHD
☐	☐	Anemia
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints Arthritis
☐	☐	Asthma
☐	☐	Blood Disease
☐	☐	Bruise Easily
☐	☐	Blood Thinners
☐	☐	Calcium Deficiency
☐	☐	Cancer Type:
☐	☐	Chemotherapy
☐	☐	Diabetes
☐	☐	Contact Lenses
☐	☐	Digestive Disorders
☐	☐	Dizziness/Fainting
☐	☐	Drug Addiction Alcohol Intake Daily:
☐	☐	Emphysema

Y	N	
☐	☐	Endocarditis
☐	☐	Excessive Bleeding
☐	☐	Glaucoma
☐	☐	Head/Neck Injuries
☐	☐	Heart Conditions
☐	☐	Heart Murmur
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	HIV/AIDS
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Mitral Valve Prolapse

Y	N	
☐	☐	Nervousness/Depression
☐	☐	Pacemaker
☐	☐	Phen Fen (1 month+)

PRE-MEDICATION FOR:

Y	N	
☐	☐	Osteoporosis
☐	☐	Osteopenia
☐	☐	Radiation (head/neck)
☐	☐	Respiratory Fever
☐	☐	Rheumatism
☐	☐	Scarlet Fever
☐	☐	Seizures
☐	☐	Stomach Problems
☐	☐	Stroke
☐	☐	Thyroid Disease

Y	N	
☐	☐	Tuberculosis
☐	☐	Tumor/Abnormal
☐	☐	Ulcers
☐	☐	OTHER (please list):

_____

_____

_____

_____

_____

Y	N	
☐	☐	Prion Disease

FOR WOMEN ONLY:

Y	N	
☐	☐	Birth Control Pills
☐	☐	Breast Feeding
☐	☐	Pregnant 1-3 mo, 3-6 mo, 6-9 mo

DO YOU HAVE AN ALLERGY TO ANY OF THE FOLLOWING?

☐	☐	Aspirin	☐	☐	Codeine
☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Latex	☐	☐	Tetracycline
☐	☐	Local Anesthetic	☐	☐	Sulfa
☐	☐	Nitrous Oxide	☐	☐	Fluoride

Y ☐ N ☐ Aspirin Daily

☐	☐	Ibuprofen
☐	☐	Acetaminophen
☐	☐	Metals (Nickel, Gold, Silver)
☐	☐	Other

_____

_____

ARE YOU UNDER A PHYSICIAN'S CARE? FOR WHAT?

_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

_____

_____

_____

IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION WE SHOULD KNOW ABOUT?

_____

_____

_____

Patient Signature (or Parent of Child) Date Dentist's Signature

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PATIENT REGISTRATION

Patient's Name | **Birth date** | **Age** | **Sex: M F**

Home Address | **City** | **State** | **Zip**

Home Phone #

Work Phone #

YOUR Cell Phone #

YOUR Email Address | **YOUR Soc Sec #**

YOUR Driver's License Number (is not necessary if you are paying at time of service)

Your Place of Employment | **Your Occupation**

Please Circle One: **Single** **Married** **Separated** **Widow**

If patient is minor, we need:

Mother's Name & Birth Date

Father's Name & Birth Date

Person paying this bill:

Name of spouse (or parent if minor):

Spouse's (or parent's) employer | **Spouse's Soc. Sec. #** | **Work Phone #**

EMERGENCY INFORMATION

Name, Address & Telephone of A relative not living with you:

Family Physician: | **Phone Number:**

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name | **DOB** | **SS #**

Insured's employer

Insurance Co.

Insurance Co. Address

Phone #

Group # | **Policy #**

Patient Signature (or Parent of Child) | **Date** | **Dentist's Signature**

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CLIENT PHOTO RELEASE FORM

I, _____, hereby authorize Vaca & Kirby Dental Group to take photographs, x-rays, intra-oral, slides and /or videos of my facial area, jaws, teeth or anything in reference to my dental treatment.

I understand that these diagnostic tools will be used as a record of my care and may be used for educational purposes in lectures, demonstrations and advertising. Their use may include, but are not limited to, website publication, newspapers, magazines, phone books, television and professional (dental magazines and journals), videos and social media.

I also understand that if the photographs, x-rays, intra-oral, slides and/or videos of my facial area, jaws, teeth or anything in reference to my dental treatment are used in any type of marketing publication or as part of any presentation or demonstration, that my name or other identifying information may be used unless otherwise stated below. I do not expect compensation, financial or otherwise, for the use of photographs. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

PLEASE INITIAL:

____ I do not mind if my name and face are used in any of the above mentioned situations.

EXCEPTIONS:

____ I do not wish to have my name shown or released.

____ I do not wish to have my face shown.

Signature: _____ Date: _____

If patient is a minor:
Parent/Legal Guardian: _____ Date: _____

Signature: _____ Date: _____

3121 H.G. Mosley Pkwy, Longview, Texas 75605 • O: (903) 633-0861 • F: (903) 663-9148

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STOP-BANG Questionnaire

1. Do you **Snore** loudly (louder than talking or loud enough to be heard through closed doors)?
   ☐ Yes ☐ No
2. Do you often feel **Tired**, fatigued, or sleepy during daytime?
   ☐ Yes ☐ No
3. Has anyone **Observed** you stop breathing during your sleep?
   ☐ Yes ☐ No
4. Do you have or are you being treated for high blood **Pressure**?
   ☐ Yes ☐ No
5. **Body** Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?
   ☐ Yes ☐ No

   BMI Formula:

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

6. **Age** over 50 yr old?
   ☐ Yes ☐ No
7. **Neck** circumference greater than 40 cm?
   ☐ Yes ☐ No
8. **Gender** male?
   ☐ Yes ☐ No

Scoring:
Answering **"yes"** to **three or more** of the 8 questions indicates that you are at **High Risk** for OSA. Answering **"yes"** to **less than three** questions indicates that you are at Low Risk for OSA. If you scored in the **High Risk for OSA** category, a **sleep study** or an **evaluation** by a **sleep specialist** may be warranted.

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Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

This consent form allows Vaca & Kirby Dental Group to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Vaca & Kirby Dental Group has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Vaca & Kirby Dental Group.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Vaca & Kirby Dental services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Vaca & Kirby dental Group may refuse service if I revoke this consent.

I understand that I have the right to request — now and in the future — how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Vaca & Kirby Dental Group is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor)/
Authorized Representative _____ Date: _____

_____ Initial I hereby authorize Vaca & Kirby Dental Group to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

_____ Initial I hereby authorize that Vaca & Kirby Dental Group may leave messages on my voicemail to confirm appointments, and/or speak with other members of my household and leave messages with them regarding my appointments.

__Email __Home Phone __Office Phone __Cell Phone

_____ Initial I hereby authorize that Vaca & Kirby Dental Group may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

_____ Initial I hereby authorize that Vaca & Kirby Dental Group may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that Vaca & Kirby Dental Group may disclose my personal health information to the following person(s).

Name	Telephone Number	Relationship to Patient