DR. LYNDSAY H. MCCASLIN
EXPRESSIONS
Cosmetic & Family Dentistry

Lyndsay H. McCaslin, DMD
Laura Goodwin, DMD

Patient History and Information

Date: _____

Name: Dr Mr Mrs Ms _____ Date of Birth: _____ Age: _____
Spouse/Guardian Name: _____ Marital Status: S M D W Gender: M F
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Best way to reach you During the Day: _____ Email: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Social Security No.: _____ Driver's License No.: _____
Dental Insurance? ☐Yes ☐No Company Name: _____ Phone: _____
Who Referred You to Us? _____
What are your Hobbies/Special Interests? _____

Dental History

Date of Last Dental Exam: _____ Name/Location of Former Dentist: _____
What brings you to our Office? _____

Please Answer the Following Questions (Descriptions can be placed under Remarks):

	Yes	No		Yes	No
Discomfort with Hot liquids/foods	☐	☐	Do you Brush (Frequency _____)	☐	☐
Discomfort with Cold liquids/foods	☐	☐	Do you Floss (Frequency _____)	☐	☐
Discomfort with Sweets/Sours	☐	☐	Do your Gums Bleed	☐	☐
Sensitivity in one area of the mouth	☐	☐	Gums feel Tender/ Swollen	☐	☐
Jaw Joint Sounds	☐	☐	Past Diagnosis/Treatment for Gum Disease	☐	☐
Chewing on One Side of the Mouth	☐	☐	Do you have any "Loose" Teeth	☐	☐
Jaw Locking or Catching	☐	☐	Pain in Face or Inside the Mouth	☐	☐
Jaw Pain or Aches	☐	☐	Frequent Headaches	☐	☐
Difficulty Opening/Closing/Chewing	☐	☐	Injury to the Face/Head/Neck	☐	☐
Do you have Missing Teeth	☐	☐	Clenching or Grinding Teeth	☐	☐
Prolonged Bleeding after Extractions	☐	☐	Worn Braces or had Orthodontics	☐	☐
Do you wear a Partial Denture	☐	☐ →	If so, how long? _____ Fits good?	☐	☐
Upper and/or Lower Dentures	☐	☐ →	If so, how long? _____ Fits good?	☐	☐

Remarks: _____

	Yes	No		Yes	No
Do you like the way your teeth look?	☐	☐	Any interest in Whitening/Bleaching?	☐	☐
Is there any Previous or Older Dental Treatment you are not happy with?				☐	☐

What would you like to Change about your Smile? _____

I desire to keep my own teeth for life. I want my teeth to feel good, look good, and last.	☐	☐
I am interested in a plan for long-term dental health.	☐	☐
Phasing Treatment, by Priority, may make it feasible for me to achieve the results I desire.	☐	☐
A Payment Plan through a Secondary Company may help me achieve the results I desire.	☐	☐
Are you Anxious about Dental Treatment?	☐	☐
Have you ever required **"Pre-Medication"** Antibiotics before your dental work?	☐	☐

Please List any Additional Concerns about your mouth _____

CONTINUE BACK PAGE ⇒

Medical History Form

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Rate your overall energy level (Low) 1-10 (Excellent)

Rate your sleep quality (Low) 1-10 (Excellent)

Have you been told you snore?

☐ YES ☐ NO ☐ SOMETIMES

Rate the sound of your snoring (Quiet) 1-10 (Loud)

On average, how many times per night do you wake up?

On average, how many hours of sleep do you get per night?

How often do you awaken with headaches?

☐ NEVER ☐ RARELY ☐ SOMETIMES

☐ OFTEN ☐ EVERYDAY

Do you have a bed partner?

☐ YES ☐ NO ☐ SOMETIMES

Do you sleep in the same room?

☐ YES ☐ NO

How many times per night does your bedtime partner notice that you stop breathing?

☐ SEVERAL TIMES PER NIGHT ☐ ONCE PER NIGHT ☐ SEVERAL TIMES PER WEEK

☐ OCCASIONALLY ☐ SELDOM ☐ NEVER

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Dr. Lyndsay H. McCaslin
EXPRESSIONS
Cosmetic & Family Dentistry

Lyndsay H McCaslin, DMD
Laura Goodwin, DMD

Your Financial Options

Thank You for selecting us as your dental health care provider

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of your financial options that we require you to read and sign prior to treatment

- Full payment is due at the time of service unless other arrangements have been made. We graciously accept Checks, Visa, MasterCard, Discover and American Express
- For Patients with comprehensive treatment plans, we offer a definitive payment plan for 3 months with no interest
- We offer extended payment plans with prior credit approval by outside lending organizations such as:
    - Care Credit: 12-18 months interest free, with a processing fee that will be calculated to 7% your total comprehensive treatment plan.

We gladly file your insurance

Your insurance policy is a contract between you and your insurance company. It is important to know that professional services are rendered and charged to you, the patient. Because different insurance companies reimburse the office at their own "Usual and Customary Fee" rates, there will be an In-Office co-pay for each visit of treatment to you, the patient. Should your total treatment be covered under your plan, our office will reimburse you, or add a credit to your account after the Insurance Coverage has been received.

Not all dental services may be covered under your particular plan. Diagnosis and treatment are determined by your doctor, not your insurance company.

Our obligation is to help you as much as we can by completing all forms pertaining to your claim and submitting them promptly to your company. This helps you obtain the reimbursement you are entitled to receive as quickly as possible.

Minor Patients

The parent or guardian accompanying a minor is responsible for the full payment regardless of any insurance coverage through a divorced parent situation. For unaccompanied minors, non- emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover, or payment by Cash or Check at the time of service.

Thank you for understanding our financial options. Please let our receptionist know if you have any questions or concerns.

I have read, understand, and agree to the provisions of these Benefit Options. In the event of defaults in the payment of arrangements made, and if these arrangements are placed in the hands of an attorney at law for collection, the undersigned hereby agrees to pay all costs of collection including a reasonable attorney's fee. Presentment protest and notice are hereby waived.

X_____ X_____

Signature of Patient or Responsible Party — Date

Keeping your Scheduled Appointments are Very Important at our Office ...

Unless cancelled *at least 24 hours* in advance *WEEKDAY*, and
at least 48 hours in advance for *SATURDAY*,
there will be a fee for missed appointments at the rate of a $50 per hour of time.
Please help us serve you better by keeping all scheduled appointments.

X_____ X_____

Signature of Patient or Responsible Party — Date

Dr. Lyndsay H. McCaslin
EXPRESSIONS
Cosmetic & Family Dentistry

Consent and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME: _____
ADDRESS: _____
TELEPHONE: _____ EMAIL: _____
SOCIAL SECURITY NUMBER: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure if your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of treatment, payment, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice Accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in out Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will include the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notices of Privacy Practices, including any revisions of our Notices, at any time by contacting:

Expressions Cosmetic & Family Dentistry
Dr. Lyndsay H. McCaslin and Dr Laura Goodwin
3007 Ridgeline Blvd Ste A, Tarpon Springs, FL 34688
Phone: 727-787-6453
Email: office@myexpressionsdentistry.com

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue to treat you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

SIGNATURE: _____ **DATE:** _____

If a personal representative on behalf of the patient signs this consent, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

**** YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT****

Dr. Lyndsay H. McCaslin
EXPRESSIONS
Cosmetic & Family Dentistry

Lyndsay H McCaslin, DMD
Laura Goodwin, DMD

Understanding Your Dental Benefits

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of your Dental Benefits that we require you to read and sign prior to treatment.

We Gladly File Your Insurance

Your insurance policy is a contract between you and your insurance company. It is important to know that professional services are rendered and charged to you, the patient.

It is our responsibility to provide the utmost quality of care. **Diagnosis and treatment are determined by your Doctor, not your insurance company.** Our obligation is to help you as much as we can by completing all forms pertaining to your claim and submitting them promptly to your insurance company. This helps you obtain the reimbursement you are entitled to receive as quickly as possible.

Because different insurance companies reimburse the office at their own "Usual and Customary Fee" rates (which may be lower than ours), **there will be an In-Office Co-Pay for each visit of treatment** to you, the patient. Should your total treatment be covered under your plan, our office will reimburse you, or add the credit to your account after the Insurance Coverage has been received.

As your doctor may be a "Provider" on your particular plan, this does not mean that each visit is covered at 100%. Not all dental services may be covered under your particular plan (i.e. Crowns, Gum Disease Treatment, and/or White Fillings). You may be obligated to pay the additional fee that your insurance does not cover. **At your request, we are willing to send a Pre-Determination to your Insurance Company before treatment so you have a greater understanding of your financial responsibilities.**

Please Research your Insurance Company before your visit with us, so that we are able to serve you and answer any questions you may have. If there is a question about your Insurance Payment, or non-payment, we will be happy to assist you as much as we can, but the question and answers also should be directed to your particular Insurance Company. The more information the company receives, the greater chance the industry will change.

Thank you for understanding our Benefit Options. Please let our receptionist know if you have any questions or concerns.

I have read, understand, and agree to the provisions of these Benefit Options. In the event of defaults in the payment of arrangements made, and if these arrangements are placed in the hands of an attorney at law for collection, the undersigned hereby agrees to pay all costs of collection including a reasonable attorney's fee. Presentment protest and notice hereby waived.

X_____ X_____

Signature of Patient or Responsible Party Date

VELscope Vx
Enhanced Oral Assessment

Dr. Lyndsay H. McCaslin
EXPRESSIONS
Cosmetic & Family Dentistry

Oral Cancer Screening Consent Form

Did you know that One American Dies from Oral Cancer Every Hour?

In 2013, Dr. McCaslin's mother, Becky, was one of these victims – and we want to prevent this tragedy for you and your family.

Tobacco, Alcohol, and the HPV virus are considered major pre-disposing risk factors to Oral Cancer, **but more than 25% of oral cancer victims have no such lifestyle risk factors. For this reason, we believe that all individuals over the age of 18 should have an annual Comprehensive Oral Cancer Exam.**

At our office, we have incorporated the VELscope Oral Cancer Screening System. This 3 minute exam has been cleared by the FDA and is used to assist Dr. McCaslin, and her hygienists in detecting cancerous and pre-cancerous growths that may not appear to the naked eye.

This screening is completely pain free, and is affordably priced. At approximately $19 (which may or may not be a covered Insurance benefit), isn't it worth the peace of mind?

YES! I would prefer to have the VELscope Oral Screening at this time.

Print Name _____

Sign _____ Date_____

No.... I would prefer NOT to have the VELscope Oral Screening at this time.

Print Name _____

Sign _____ Date_____