Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Employer: _____ Occupation: _____

Drivers License: _____ Cell Phone: _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Bleeding or Clotting Disorders
☐ Blood Transfusion
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Fen Phen
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Lung Problems
☐ Mental Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems, Asthma
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tobacco User
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

OTHER:
☐ Bisphosphonates (i.e. Fosamax, Aredia, Actonel, Zometa)
☐ _____

- Please list all over the counter and prescription medicines you are currently taking:

_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Cancellation Policy

The Cancellation Policy for this dental practice requires at least a 24 hour notice to cancel and/or reschedule your appointment. We reserve the right to charge a $38.00 fee for those patients who do not comply with this policy.

_____ _____
Patient's Signature Date

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:_____ Social Security #: _____ _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Drivers License: _____ Cell Phone: _____ Email: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Insurance Information

(If different than Responsible Party)

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

ADULT SLEEP EVALUATION

Addendum to Health History:

NAME:_____ AGE:_____ Ht: _____ft _____in Wt: _____lbs
Date:_____

1. Have you ever had a sleep evaluation before? YES / NO
2. If yes, have been diagnosed with a sleep disorder? YES/NO
3. Have you been recommended to use a C-PAP?
4. If yes, are you currently using a treatment device/C-PAP? YES / NO Regularly? YES / NO
5. What type of device if other than a C-PAP _____
6. Please answer the questions below:

EPWORTH SLEEPINESS SCALE

Dr. Murray Johns of Melbourne, Australia developed and validated the Epworth Sleepiness Scale (ESS). Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991: 14(6):540-5

How likely are you to doze off or fall asleep in the following situations?

Situation	**Score**
Sitting & reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting & talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
Total score	**_____**

Scale

0 = would never dose

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

A score of less than 8 may indicate normal sleep functions

8-10 = Mild Sleepiness

11-15 = Moderate Sleepiness

16-20 = Severe Sleepiness

21-24 = Excessive Sleepiness