Welcome

Please fill out this form completely, it is important to your care.

ABOUT YOU

Today's Date: _____ ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name: _____ (LAST / FIRST / MI) ☐ M ☐ F Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____ (CITY / STATE / ZIP)

Hm #: (_____) _____ Cell #: (_____) _____ Wk #: (_____) _____ DL #: _____

E-Mail Address: _____ When are the best times to reach you? _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ (CITY / STATE / ZIP)

General Doctor: _____ Previous or Present (Please circle) Date of last visit: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____ Wk #: (_____) _____

Hm #: (_____) _____ Address: _____ (CITY / STATE / ZIP)

SPOUSE INFORMATION

His/Her Name: _____ Birthdate: ___/___/___ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Person Responsible for Account, if other than yourself

Name: _____ Relation: _____ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Hm #: (_____) _____ Billing Address: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____ Employer's Address: _____ (CITY / STATE / ZIP)

Secondary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____ Employer's Address: _____ (CITY / STATE / ZIP)

HISTORY

Why have you come to the doctor today? _____

_____

Are you currently in pain? ☐ Y ☐ N

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Have you experienced problems associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Y ☐ N Do you brush daily? ☐ Y ☐ N

Type of bristles on toothbrush: ☐ Hard ☐ Medium ☐ Soft

How often do you replace your toothbrush? _____

Do you use anything in addition to your brush and floss? ☐ Y ☐ N

If yes, what? _____

Would you like fresher breath? ☐ Y ☐ N Whiter teeth? ☐ Y ☐ N

Do your gums bleed? ☐ Y ☐ N Do gums itch? ☐ Y ☐ N

Have you ever had periodontal disease? ☐ Y ☐ N

Do you have mobility in your teeth? ☐ Y ☐ N

Are your teeth sensitive to heat, cold or anything else? _____

Do you still have wisdom teeth? ☐ Y ☐ N

If yes, why? _____

Previous Doctor: _____ Date of last visit: _____

Why did you leave your previous dentist? _____

What did you like most / least about any dentist you have seen?

_____

Are you happy with the way your smile looks? ☐ Y ☐ N

If not, what would you change? _____

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Address: _____

Phone #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs / materials that cause allergic reactions:

_____ _____

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Pressure Medication	Y N Recreational Drugs
Y N Antibiotics	Y N Cold Remedies	Y N Steroids / Cortisone
Y N Antihistamines	Y N Digitalis / Heart Medication	Y N Thyroid Medicine
Y N Aspirin	Y N Insulin / Diabetes Drugs	Y N Tranquilizers
Y N Blood Thinners	Y N Nitroglycerin	

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

Have you ever taken Fosamax or any other bisphosphonate? ☐ Y ☐ N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Y ☐ N

If yes, please list each one _____

_____

WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Unsure ☐ Y ☐ N Week #_____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones / Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____.

_____ _____

SIGNATURE DATE

PAYMENT IS DUE AT TIME OF SERVICE.

I certify that I am covered by _____ Insurance Co.

and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

SIGNATURE DATE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Name	DOB/Height/Weight	Date

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Y / N	8	Have you ever been told you stop breathing while asleep?
Y / N	6	Have you ever fallen asleep or nodded off while driving?
Y / N	6	Have you ever woken up suddenly short of breath, gasping or with your heart racing?
Y / N	4	Do you feel excessively sleepy during the day?
Y / N	4	Do you snore, or have you ever been told that you snore?
Y / N	2	Have you had weight gain and found it difficult to lose?
Y / N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y / N	3	Do you kick or jerk your legs while sleeping?
Y / N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y / N	3	Do you wake up with headaches during the night or in the morning?
Y / N	4	Do you have trouble falling asleep?
Y / N	4	Do you have trouble staying asleep once you fall asleep?
		Total Score

FOR CLINICAL USE

Low	Moderate	High	Severe
0 - 7	8 - 11	12 - 15	16 +

Visual Indications:

☐ Enlarged / Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate ☐ Bruxism

☐ Gastroesophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using CPAP machine? ☐ Yes ☐ No (If yes) Do you use it every night? ☐ Yes ☐ No

Notes: