Patient Registration

CURRENT DATE: __/__/____

First Name _____ **Last Name** _____ **Middle Initial** _____

Patient Information

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext. ____ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date _____ Soc Sec # _____

E-mail _____ Spouse Name _____

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: Feet ___ Inches ___

Responsible Party Information

First Name _____ **Last Name** _____ **Middle Initial** _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext. ____ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date _____ Soc Sec # _____

E-mail _____

DENTAL INSURANCE INFORMATION

Primary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Relationship to Insured ☐ Self ☐ Spouse

Insurance ID No. _____ ☐ Child ☐ Other

Insured Birth Date _____ Subscriber SS # _____

Employer _____

Insured Address if different than patient's

Street Address _____

City, State, Zip _____

Ins. Company _____

Street Address _____

_____

City, State, Zip _____

Secondary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Subscriber SS # _____

Insured Birth Date _____ Sex: Insurance ID No. _____

Employer _____

Insured Address if different than patient's

Street Address _____

City, State, Zip _____

Ins. Company _____

Street Address _____

_____

City, State, Zip _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Relationship to insured ☐ Self ☐ Spouse

Insurance ID No. _____ ☐ Child ☐ Other

Insured Birth Date _____ Subscriber SS # _____

Employer _____ Ins. Company _____

Insured Address if different than patient's Street Address _____

Street Address _____ _____

City, State, Zip _____ City, State, Zip _____

Secondary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Subscriber SS # _____

Insured Birth Date _____ Sex: Insurance ID No. _____

Employer _____ Ins. Company _____

Insured Address if different than patient's Street Address _____

Street Address _____ _____

City, State, Zip _____ City, State, Zip _____

Whom may we thank for referring you to our pratice:

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1;/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Medical History Questionnaire

OFFICE USE
Patient ID:

NAME: _____ FORM DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	A.I.D.S. / H.I.V Positive	☐	☐		☐	Asthma	☐	☐	
☐	Acid reflux	☐	☐		☐	Autoimmune disorder	☐	☐	
☐	Allergies or Hives	☐	☐		☐	Birth Defects	☐	☐	
☐	Anemia	☐	☐		☐	Bleeding easily	☐	☐	
☐	Anxiety	☐	☐		☐	Blood pressure - High	☐	☐	
☐	Anxious / Nervous	☐	☐		☐	Blood pressure - Low	☐	☐	
☐	Artificial Joints (hip,knee,etc.)	☐	☐		☐	Bruising easily	☐	☐	
☐	Arteriosclerosis	☐	☐		☐	Blood Transfusion	☐	☐	
☐	Arthritis	☐	☐		☐	Cancer	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current Never	Current Past	Date / Note	Significant	Medical Condition	Current Never	Current Past	Date / Note
☐	Chemotherapy	☐	☐		☐	Frequent ear infections	☐	☐	
☐	Chronic Cough	☐	☐		☐	Frequent cough	☐	☐	
☐	Chronic fatigue	☐	☐		☐	Frequent sore throat	☐	☐	
☐	Chronic pain	☐	☐		☐	Gastroesophpgeal Reflex (Gerd)	☐	☐	
☐	COPD	☐	☐		☐	Glaucoma	☐	☐	
☐	Cold hands and feet	☐	☐		☐	Gout	☐	☐	
☐	Cold Sores / Fever Blisters	☐	☐		☐	Hay Fever	☐	☐	
☐	Congenital Heart Disease	☐	☐		☐	Hearing impairment	☐	☐	
☐	Contact lenses	☐	☐		☐	Heart attack	☐	☐	
☐	Cortisone Medicine	☐	☐		☐	Heart disorder	☐	☐	
☐	Current pregnancy	☐	☐		☐	Heart murmur	☐	☐	
☐	Depression	☐	☐		☐	Heart pacemaker	☐	☐	
☐	Diabetes	☐	☐		☐	Heart valve replacement	☐	☐	
☐	Diet (Special / Restricted)	☐	☐		☐	Hemophilia	☐	☐	
☐	Difficulty breathing at night for sleep	☐	☐		☐	Hepatitis A	☐	☐	
☐	Difficulty concentrating	☐	☐		☐	Hepatitis B	☐	☐	
☐	Difficulty sleeping	☐	☐		☐	Hepatitis C	☐	☐	
☐	Dizziness	☐	☐		☐	History of Substance Abuse	☐	☐	
☐	Emphysema	☐	☐		☐	Huntington's Diease	☐	☐	
☐	Epilepsy	☐	☐		☐	Hypertension	☐	☐	
☐	Fainting	☐	☐		☐	Hypoglycemia	☐	☐	
☐	Excessive Thirst	☐	☐		☐	Insomnia	☐	☐	
☐	Fibromyalgia	☐	☐		☐	Intestinal Disorder	☐	☐	
☐	Fluid Retention	☐	☐		☐	Immune system disorder	☐	☐	
☐	Frequent awaking at night	☐	☐		☐	Jaundice (yellowing of skin or eyes)	☐	☐	
☐	Frequent colds/flu	☐	☐		☐	Kidney problems	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current Never	Current Past	Date / Note	Significant	Medical Condition	Current Never	Current Past	Date / Note
☐	Latex Sensitivity	☐	☐		☐	Recent weight gain	☐	☐	
☐	Leukemia	☐	☐		☐	Recent weight loss	☐	☐	
☐	Liver disease	☐	☐		☐	Rheumatic fever	☐	☐	
☐	Memory Loss	☐	☐		☐	Rheumatoid arthritis	☐	☐	
☐	Meniere's disease	☐	☐		☐	Seizures	☐	☐	
☐	Migraines	☐	☐		☐	Scarlet Fever	☐	☐	
☐	Mitral valve prolapse	☐	☐		☐	Shortness of breath	☐	☐	
☐	Multiple sclerosis	☐	☐		☐	Sickle Cell Disease	☐	☐	
☐	Muscle aches	☐	☐		☐	Sinus problems	☐	☐	
☐	Muscle fatigue	☐	☐		☐	Skin Disorder	☐	☐	
☐	Muscle spasms	☐	☐		☐	Sleep apnea	☐	☐	
☐	Muscle tremors	☐	☐		☐	Slow healing sores	☐	☐	
☐	Muscular dystrophy	☐	☐		☐	Speech difficulties	☐	☐	
☐	Nasal allergies	☐	☐		☐	Stroke	☐	☐	
☐	Neuralgia	☐	☐		☐	Swollen Ankles	☐	☐	
☐	Neurological Disorders	☐	☐		☐	Swollen, stiff or painful joints	☐	☐	
☐	Nervous System Disorder	☐	☐		☐	Tendency for ear infections	☐	☐	
☐	Osteoarthritis	☐	☐		☐	Tired muscles	☐	☐	
☐	Osteoporosis	☐	☐		☐	Thyroid disorder	☐	☐	
☐	Overian Cysts	☐	☐		☐	Tuberculosis	☐	☐	
☐	Parkinson's disease	☐	☐		☐	Tumors	☐	☐	
☐	Poor circulation	☐	☐		☐	Ulcers	☐	☐	
☐	Psychiatric care	☐	☐		☐	Urinary disorders	☐	☐	
☐	Radiation treatment	☐	☐		☐	Venereal Disease	☐	☐	

Other

Medical Condition	Current	Past	Date / Note	Medical Condition	Current	Past	Date / Note
☐	☐	☐		☐	☐	☐	

Patient Signature: _____ Date: _____

If you have any heart problems, what kind (s)?

☐ Yes ☐ No Have you been told you have a heart murmur?

☐ Yes ☐ No Do you have a current medical problem?

Blood pressure
- ☐ normal
- ☐ high and controlled
- ☐ high and not controlled
- ☐ low and controlled
- ☐ low and uncontrolled
- ☐

If you have had rheumatic fever, when?

☐ Yes ☐ No Do you have any pain in your chest or shortness of breath?

☐ Yes ☐ No Do your ankles swell?

☐ Yes ☐ No Has your physician ever told you that you are anemic?

If you have had a stroke, when?

If you have headaches, how often and where?

If you take Aspirin, Advil, Tylenol or another pain reliever, how often?

If you have been advised not to take any medications, which?

If you have asthma or hay fever, how is it controlled?

If you have had tuberculosis, when?

Have you ever had glaucoma, when?

If you have ever had hepatitis, when?

If you have arthritis, how is it controlled?

If you ever had a severe blow to the head, when?

If your hands and/or feet are sometimes cold, how often?

If your diet is medically supervised, for what purpose?

☐ Yes ☐ No Do you have difficulty swallowing?

☐ Yes ☐ No Do you have a feeling of something stuck in your throat?

If you ever have any facial pain or pressure, where?

☐ Yes ☐ No Do you ever have any pain or pressure behind your eyes?

If you are aware of stiff neck muscles, how often?

If you have ever been in traction for a neck injury, when?

☐ Yes ☐ No Have you ever had or been advised to have neck surgery?

If you have back pain, where?

☐ Yes ☐ No Do your ears feel itchy, stuffy, or congested?

☐ Yes ☐ No Do you have difficulty with pain in your ears when changing altitude?

If your ears ring, buzz, or hiss, how often?

Patient Signature:

Date:

Medical History

☐ Yes ☐ No Have you noticed any changes in your hearing?

☐ Yes ☐ No Are you depressed?

☐ Yes ☐ No Do you have emotional or anxiety/nervousness problems?

If you have gained weight within the last year, how much? _____

If you have lost weight within the last year, how much? _____

If you have had any other serious illness, hospitalization or accidents, please explain: _____

DENTAL HISTORY

When was your last dental visit? _____

☐ Yes ☐ No Have you been told that you have periodontal (gum) disease?

If you have any existing problems with your teeth, describe: _____

If you have any dental treatment planned, describe: _____

☐ Yes ☐ No Do you bite your nails?

☐ Yes ☐ No Have you ever had any oral surgery?

If you have lost any teeth, from what cause? _____

If so, when have the teeth been replaced? _____

If you have had orthodontic treatment, when? _____

If you have ever had extensive dental treatment, when? _____

If any part of your mouth is sensitive to temperature, pressure, food or drink, where? _____

☐ Yes ☐ No Do you wear dentures or partial dentures?

☐ Yes ☐ No If so, are they comfortable?

TMJ HISTORY

☐ Yes ☐ No Do you ever have a burning or painful sensation in your mouth?

☐ Yes ☐ No Do you get popping, clicking, or grinding noises when you open or close?

☐ Yes ☐ No Do you ever awaken with an awareness of your teeth or jaws?

If you are aware of clenching during the daytime, how often? _____

☐ Yes ☐ No Have you ever been told you grind your teeth during sleep?

☐ Yes ☐ No Do you have trouble opening your mouth widely?

If your jaw ever locks open or closed, how often? _____

☐ Yes ☐ No Do you feel your bite is different, unstable or uncomfortable?

What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems? _____

☐ Yes ☐ No If you have sought treatment for a TMJ problem, did it help?

Do you or have you had any pain in the following areas?

☐ Jaw

Patient Signature: _____ Date: _____

Do you or have you had any pain in the following areas?

- ☐ Ear
- ☐ Face
- ☐ Neck
- ☐ Teeth

Other

☐ Head

☐ Yes ☐ No Do your jaw problems affect your ability to chew?

If your diet has changed due to your jaw problems, describe:

☐ Yes ☐ No Do your joint noises affect others while eating?

Dental History

Current dental problems (if any)

Date of last complete dental examination

- ☐ Sensitive teeth
- ☐ Gums bleed or hurt
- ☐ Loose teeth
- ☐ Noticed a change in bite
- ☐ Mouth odors or bad tastes
- ☐ Food becomes caught between your teeth
- ☐ Clench or grind your teeth
- ☐ Had past Orthodontic treatment

Other

- ☐ Have seen a Periodontist
- ☐ Your bite has been adjusted in the past
- ☐ Jaw clicks or pops
- ☐ Difficulty opening or closing mouth
- ☐ Have been told you have a TMJ problem
- ☐ Frequent headaches
- ☐ Want to keep your teeth all your life

If you feel nervous about having dental treatment, what is your biggest concern?

If you have ever had an upsetting dental experience, describe it briefly

If you are not happy with the appearance of your teeth, what would you like to change?

Surgical Operations

- ☐ Appendectomy
- ☐ Back
- ☐ Ear
- ☐ Gallbladder
- ☐ Heart
- ☐ Hernia repair
- ☐ Lung
- ☐ Nasal
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Uvulectomy
- ☐ Periodontal

Other

Patient Signature

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: Date:

I certify that the medical history information is complete and accurate.

Patient Signature: Date:

Patient Health Questionnaire

What is the chief complaint for which you are seeking treatment in our office?

Note: Please identify your *chief complaint* with the *number 1*, list all *other symptoms* in priority with the *numbers 2-10.*

	Recent	Chronic(6 mo+)
____Headache Pain	___	___
____Ear Pain	___	___
____Jaw Pain	___	___
____Pain when chewing	___	___
____Facial Pain	___	___
____Eye Pain	___	___
____Throat Pain	___	___
____Neck Pain	___	___
____Shoulder Pain	___	___
____Back Pain	___	___
____Limited ability to open mouth	___	___
____Jaw Joint locking	___	___
____Jaw Joint noises	___	___
____Ear Congestion	___	___
____Sinus Congestion	___	___
____Dizziness	___	___
____Tinnitus (ringing in ears)	___	___
____Muscle twitching	___	___
____Vision problems	___	___

	Recent	Chronic(6 mo+)
____Kicking or jerking leg repeatedly	___	___
____Swelling in ankles or feet	___	___
____Morning Hoarseness	___	___
____Dry mouth upon waking	___	___
____Fatigue	___	___
____Difficulty falling asleep	___	___
____Tossing and turning frequently	___	___
____Repeated awakening	___	___
____Feeling unrefreshed in the morning	___	___
____Significant daytime drowsiness	___	___
____Frequent heavy snoring	___	___
____Affects sleep of others	___	___
____Gasping when waking	___	___
____Told that "I stop breathing"during sleep	___	___
____Night-time choking spells	___	___
____Unable to tolerate C-Pap	___	___
____Tooth grinding	___	___
____Teeth crowding	___	___

Do you have concerns in any of these areas: ___General appearance ___Overbite
___Ability to Function ___Smile

Other Comments:_____

_____

Do any of the above complaints or concerns affect your daily life?_____

What are the results you are seeking from treatment?_____

Patient Signature:_____ Date:_____

Periodontal Questions

- ☐ Do your gums ever bleed?
- ☐ Have your gums receded, or do your teeth look longer?
- ☐ Have you ever been told that you have gum problems, gum infection or gum inflammation?
- ☐ Have you had any adult teeth extracted due to gum disease?
- ☐ Diet limited to liquid foods
- ☐ Diet limited to semisolid or soft foods
- ☐ Difficulty chewing
- ☐ Difficulty speaking
- ☐ Difficulty swallowing
- ☐ Digestive problems
- ☐ Gagging easily
- ☐ Mouth sores
- ☐ Nutritional disorder
- ☐ Numbness of lower lip
- ☐ Numbness in jawbone
- ☐ Tingling in jawbone
- ☐ Pain in jawbone
- ☐ Pain when chewing
- ☐ Pain when swallowing
- ☐ Poorly fitting upper dental appliance
- ☐ Swollen gums
- ☐ Sore or sensitive gums

Symptoms

HEAD PAIN

- ☐ Entire head (Generalized)
- ☐ L ☐ R ☐ B Front of your head (Frontal)
- ☐ Top of the head
- ☐ L ☐ R ☐ B Back of your head
- ☐ L ☐ R ☐ B In your temples

JAW PAIN

- ☐ L ☐ R ☐ B Jaw pain - on opening
- ☐ L ☐ R ☐ B Jaw pain - while chewing
- ☐ L ☐ R ☐ B Jaw pain - at rest

JAW SYMPTOMS

- ☐ Jaw popping
- ☐ L ☐ R ☐ B Jaw clicking
- ☐ Jaw locks closed
- ☐ Jaw locks open
- ☐ Teeth grinding

MOUTH AND NOSE RELATED CONDITION

- ☐ Burning tongue
- ☐ Frequent biting of cheek
- ☐ Frequent snoring
- ☐ Broken teeth
- ☐ Teeth clenching
- ☐ Dry mouth

EAR RELATED CONDITIONS

- ☐ Buzzing in the ears
- ☐ Tinnitus (ringing in the ears)
- ☐ Ear pain
- ☐ Ear congestion
- ☐ Pain in front of the ear
- ☐ Hearing loss
- ☐ Recurrent ear infections
- ☐ Pain behind the ear

EYE RELATED CONDITIONS

- ☐ Blurred vision
- ☐ Eye pain
- ☐ Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

- ☐ Back pain - lower
- ☐ Back pain - middle
- ☐ Back pain - upper

Patient Signature: _____ Date: _____

Symptoms

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

- ☐ Chronic sore throat
- ☐ Constant feeling of a foreign object in throat
- ☐ Difficulty in swallowing
- ☐ Limited movement of neck
- ☐ Neck pain
- ☐ Numbness in the hands or fingers
- ☐ Sciatica
- ☐ Chronic sinusitis
- ☐ Scoliosis
- ☐ Shoulder pain
- ☐ Shoulder stiffness
- ☐ Swelling in the neck
- ☐ Swollen glands
- ☐ Thyroid enlargement
- ☐ Tightness in throat
- ☐ Tingling in the hands or fingers

Other [ ] [ ]

Head Pain History

Pain Qualities

--- LOCATION ---

Which side are the headaches worse?

- ☐ both sides
- ☐ the left side
- ☐ the right side
- ☐ [ ]

Headache spreads to

- ☐ the temple
- ☐ the back of the head
- ☐ the forehead
- ☐ [ ]

--- SEVERITY ON A SCALE OF 0-10 ---

--- 0=No Pain 10=Worst Pain Imaginable ---

[ ] Jaw Pain on a Numeric Pain Scale

[ ] Headaches on a 0-10 Pain Scale

[ ] Neck Pain on a Numeric Pain Scale

[ ] Facial Pain on a 0-10 Pain Scale

FREQUENCY

- ☐ occasional (0-3/mo)
- ☐ frequent (3-6/mo)
- ☐ constant
- ☐ [ ]

--- DURATION ---

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Weeks

When having pain do you experience:

- ☐ Dizziness
- ☐ Double vision
- ☐ Fatigue
- ☐ Nausea
- ☐ Sensitivity to light (photophobia)
- ☐ Sensitivity to noise
- ☐ Throbbing
- ☐ Vomiting
- ☐ Burning

Other [ ] [ ]

Patient Signature: [ ] Date: [ ]

When did the pain or condition first occur?

Is there anything that makes your pain or discomfort worse?

What do you believe is the cause of the pain or condition

- ☐ sports injuries
- ☐ a motor vehicle accident
- ☐ a motorcycle accident
- ☐ a work related incident
- ☐ a playground incident
- ☐ an athletic endeavor
- ☐ a fight
- ☐ a fall
- ☐ an accident
- ☐ an illness
- ☐ an injury
- ☐ orthodontics
- ☐ dental procedures
- ☐ whiplash
- ☐ traumatic occlusion
- ☐

Is there anything that makes your pain or discomfort better?

What other information is important regarding the pain or condition?

Other

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Epworth Sleep Questionnaire

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

No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV

Patient Signature:

Date:

Epworth Sleep Questionnaire

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

No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	
☐	☐	☐	☐	Sitting inactive in 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

Sleep History

Previous Diagnosis

Have you been previously diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, how long ago was it? [ ] *number* ☐ Years ago ☐ Months ago ☐ Days ago

Sleep:

Sleep Onset Latency [ ] minutes

Sleep Aid ☐ Yes ☐ No

Normally goes to bed at [ ] ☐ AM ☐ PM

If yes, name the medication: [ ]

Hours of sleep per night [ ] hours

☐ Bruxism

☐ Hypnagogic Hallucinations

☐ Dry mouth

☐ Restless legs

☐ Excessive movements

☐ Waking up and having difficulty returning to sleep

☐ Gasping

☐ Dreaming

[ ] Getting up <number of times> per night

[ ] Frequency of nocturnal urination (# of times)

Witnessed apneas are:

☐ Worse during supine sleep ☐ Worse following alcohol late at night

Patient Signature: [ ]

Date: [ ]

Sleep History

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

☐ Awakens unrefreshed

Snoring is reported as:

Frequency
- ☐ seldom
- ☐ never
- ☐ daily
- ☐ often
- ☐ _____

☐ Worse during supine sleep

☐ Worse following alcohol late at night

Severity
- ☐ light
- ☐ moderate
- ☐ loud
- ☐ _____

Fatigue Scale

During the past week:	No < 1	2	3	4	5	6	7 > Yes
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: ☐

Patient Signature: _____ Date: _____

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name:

Sleep Study Date: __/__/____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of

The evaluation showed:

	during REM	*Supine*	*Side*
an RDI of			
an AHI of			

a nadir SpO_2 of T90 . ODI (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Additional Questions

☐ Yes ☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings:

CPAP Intolerance

(Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

☐ Mask leaks
☐ Inability to get the mask to fit properly
☐ Discomfort from headgear
☐ Disturbed or interrupted sleep
☐ Noise disturbing sleep and/or bed partner's sleep
☐ CPAP restricted movements during sleep
☐ CPAP does not seem to be effective
☐ Pressure on the upper lip causing tooth related problems
☐ Latex allergy
☐ Claustrophobic associations
☐ An unconscious need to remove the CPAP
☐ Does not resolve symptoms
☐ Noisy
☐ Cumbersome

Other

Other Therapy Attempts

include:

☐ Dieting
☐ Weight loss
☐ Surgery (Uvuloplasty)
☐ Surgery (Uvulectomy)
☐ Pillar procedure
☐ Smoking cessation
☐ CPAP
☐ BiPap
☐ Uvulectomy (but continues to have symptoms)
☐ Uvuloplasty (but continues to have symptoms)

Patient Signature: Date:

include:

Orthodontic Concerns

REASONS FOR VISIT

- ☐ Accident
- ☐ "Buck" or protruding teeth
- ☐ Crowded teeth
- ☐ Irregularly shaped teeth
- ☐ Mismatched bite
- ☐ Missing tooth
- ☐ Orthodontic second opinion
- ☐ Overbite
- ☐ Overly small mouth
- ☐ Prominent jaw
- ☐ Receded jaw
- ☐ Tooth spacing - excessive

TENDENCIES

- ☐ Clenching
- ☐ Grinding
- ☐ Finger sucking
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ Tongue habit

Patient Interview

☐ Past experience with dental treatments

Other

Patient Signature: _____ Date: _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

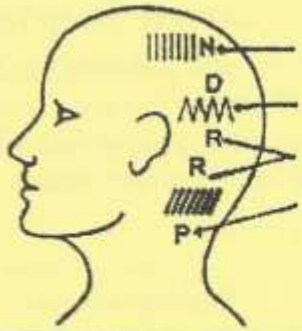
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||

MODERATE PAIN ^^^^

SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

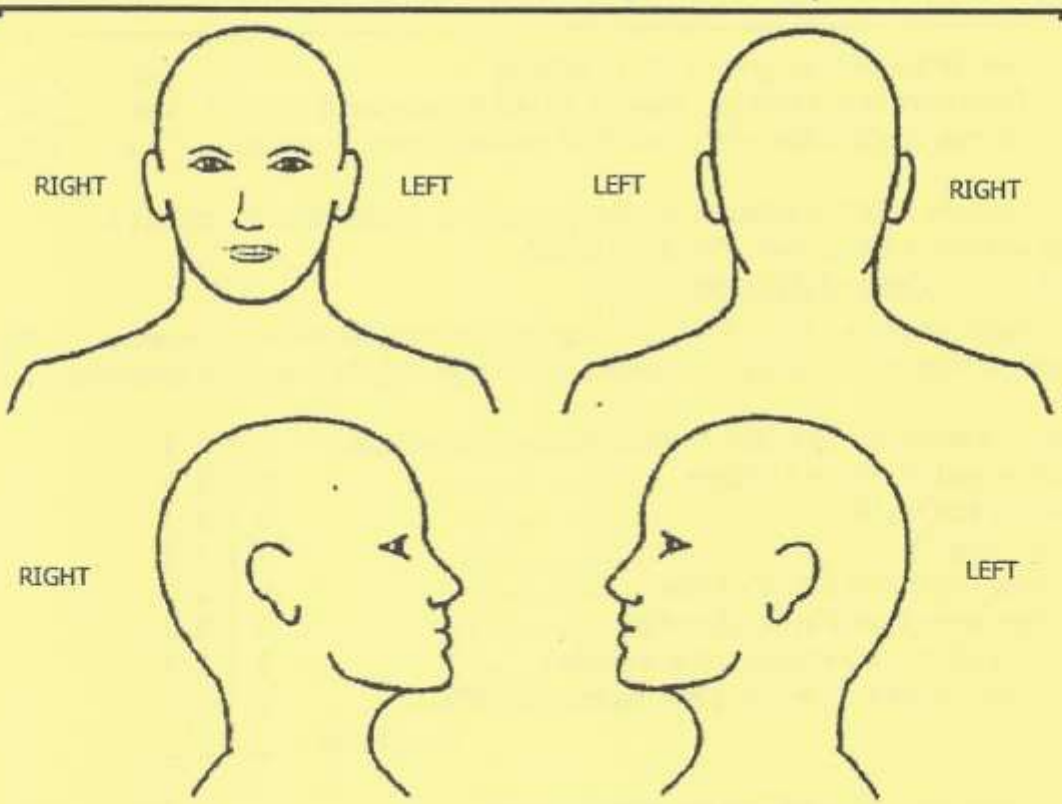


Mild, numbing pain

Moderate, dull pain

Severe, radiating pain

Pressure



Enter any text to appear below the image:

Patient Signature

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: Date:

I certify that the medical history information is complete and accurate.

Patient Signature: Date:

Weisfogel Sleep Disorder Assessment

Your physician is requesting that you complete this Sleep Assessment Form.
This form determines the need for you to have a user friendly home sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your well being and especially your cardiovascular health but can be effectively treated.

Date _____ **Name:** _____ **Date of Birth**_____

Phone Number _____ **Physician Name:** _____

Home Address_____

1 Have you ever been given a CPAP device? Yes ___ No___
2. If you have been given any form of CPAP, do you use it nightly? Yes____ No___
3. Are you comfortable with your CPAP and satisfied with its use? Yes___ N0___

If your answer is NO to either of the above questions, please continue to Part 1.
If the answer is Yes to both, PLEASE STOP.

Part 1. ***Epworth Sleepiness Scale***

How likely are you to doze off while doing the following activities? Please use the following scale: 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more 0 1 2 3
2. Sitting and talking to someone..... 0 1 2 3
3. Sitting and reading..... 0 1 2 3
4. Watching TV..... 0 1 2 3
5. Sitting inactive in a public place..... 0 1 2 3
6. Lying down to rest in the afternoon..... 0 1 2 3
7. Sitting quietly after lunch without alcohol..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic... 0 1 2 3

Total score _____

Part 2

1. Have you been told that you snore? Yes ___ No
2. Does your family have a history of premature death in sleep? Yes ___ No ___
3. Do you have Diabetes? Yes____ No____
4. Have you ever been told you have Coronary Artery Disease? Yes____ No____
5. Do you have high blood pressure? Yes ___ No ___
6. Have you ever experienced irregular heart rhythms Yes __ No ___

Part 3

1. Have you ever been diagnosed with sleep apnea? Yes____No___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes____ No___
3. Has anyone said that you seem to stop breathing while sleeping? Yes ___ No ___
4. Is your neck size larger than 15" (female) or 16.5'' (male) Yes____ No___
5. Have you ever had a stroke? Yes ___ No ___
6. Have you ever been told you have Congestive Heart Failure? Yes ___ No ___
7. Do you have or did you ever have atrial fibrillation? Yes ___ No ___

Note: Actual Neck size: _____

Physician Signature: _____ **Date:** _____

Consent for Treatment

Cypress Dental, Inc.
3138 McIlhenny Drive
Baton Rouge, LA 70809
225-248-8400

1. I hereby authorize Dr. LeJeune or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
   (Patient Name)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1/2% late charge (18% apr) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient Signature_____**Date**_____

Cypress Dental, Inc.
Kurt A. LeJeune, DDS
Office: 225-248-8400 Facsimile: 225-248-8800

OUR FINANCIAL GUIDELINES

Thank you for selecting Cypress Dental as your dental care provider. We are committed to empower you to achieve and maintain optimal oral health. We strive to provide you with and educate you in the latest techniques and restorations. Please understand that financial arrangements and payment of fees are part of your treatment. The following is a statement of our Financial Guidelines.

We accept cash, checks, Visa, MasterCard, American Express, and Discover.
Payment in full is due at the time services are rendered.
We offer third part financing, with approved credit.

Adult Patients:

Adult patients are responsible for full payment at time of service. All new patients are required to pay by cash or credit card for first visit.

Minor Patients:

All minors must be accompanied by a parent or guardian. The parent or guardian accompanying the minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, major credit card, or payment by cash or check at time of service had been verified.

Regarding Insurance:

We may accept assignment of insurance benefits, provided this information can be verified by us prior to treatment. In the event we are unable to verify insurance benefits payment in full is due at the time of service. We will be unable to bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be pre-approved with third party financing or provide a credit card with authorization to bill that account for any balance unpaid by your insurance company. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to your credit card or third party financing account. All co-payments and deductibles are due as treatment is rendered.

Usual and Customary Rates:

Our practice is committed to providing the best treatment possible. Our fees are established on the basis of what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments:

I understand that a 72 hour notification is required for **all** cancellations. If notification is not given a broken appointment fee will be charged. **The broken appointment fee is determined by the total appointment value. This fee is usually 25% of the total fee of the appointment.**

Collection and Late Fees:

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other prior arrangements have been made. In the event payments are not received by agree upon dates, I understand that a 0.5% late charge per month (18% APR) may be added to my account 30 days after services are rendered. Should your account be processed by a collection agency, all attorney, collection, and late fee will be added to your delinquent account and also become your responsibility.

Thank you for understanding our Financial Guidelines. Please let us know if you have any questions or concerns. I have read the financial guidelines. I understand and agree to this Financial Policy.

_____ _____

Signature of (Responsible Party) Date

Cypress Dental, Inc.
3138 McIlhenny Drive
Baton Rouge, LA. 70809
Office: 225-248-8400 Facsimile: 225-248-8800

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your ***Notice of Privacy Practices,*** which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are than bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20_____.

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

I authorize release of my private information in addition to the above references to:

Name: _____

Relationship to Patient: _____