Welcome

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

DATE _____

PATIENT'S NAME _____ DOB _____

SOCIAL SECURITY # _____ SEX ☐ MALE ☐ FEMALE

ADDRESS _____ CITY/ST/ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME _____ MARITAL STATUS _____

ADDRESS _____ CITY/ST/ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ DOB _____

EMPLOYER _____ OCCUPATION _____

DENTAL INSURANCE INFORMATION

POLICY OWNER'S NAME _____ SS# _____ DOB _____

INSURANCE COMPANY _____ GROUP # _____ PHONE# _____

INSURED'S EMPLOYER _____

DO YOU HAVE A SECOND COVERAGE? YES ☐ NO ☐ IF YES, complete below:

POLICY OWNER'S NAME _____ SS# _____ DOB _____

INSURANCE COMPANY _____ GROUP# _____ PHONE# _____

INSURED'S EMPLOYER _____

EMERGENCY CONTACT INFORMATION

NAME _____

PHONE _____ RELATIONSHIP _____

DENTAL HISTORY

Name _____ Age _____

Reason for today's visit _____

Former Dentist _____ Date of last exam _____ Date of last dental x-rays _____

Please check any of the following conditions that apply to you:

☐ bad breath ☐ grinding teeth ☐ sensitive teeth ☐ clicking or locking jaw ☐ bleeding gums ☐ trouble sleeping

☐ hurts to chew ☐ dry mouth ☐ broken teeth ☐ loose teeth ☐ mouth ulcers ☐ unhappy with teeth

If you checked "unhappy with teeth", what would you like to improve? (Circle all that apply)

☐ COLOR ☐ SIZE ☐ SPACING ☐ ALIGNMENT ☐ SHAPE

MEDICAL HISTORY

Physician _____ Date of last visit _____

Have you ever taken bisphosphonates for osteoporosis (Zometa, Aredia, Boniva, Actonel, or Fosamax)? _____

Have you ever had joint replacement surgery? _____ Which Joint? _____ Date _____

(Women) Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Please list all medications you are currently taking including supplements:

MEDICATION:	PRESCRIBED FOR:

(List any additional medications on back)

ALLERGIES: _____

_____

Do you have a history of the following? (Check the ones that apply)

- ☐ Heart trouble
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Epilepsy
- ☐ Smoking
- ☐ Sickle Cell
- ☐ Smokeless tobacco
- ☐ Vaping
- ☐ ADD/ADHD
- ☐ Prolonged bleeding
- ☐ Immunocompromised
- ☐ Organ Transplant
- ☐ CPAP
- ☐ Diabetes A1C _____
- ☐ Venereal disease
- ☐ Thyroid problem
- ☐ Cancer
- ☐ Chemo
- ☐ Radiation
- ☐ Stroke/Heart Attack
- ☐ Stent(s)
- ☐ High Cholesterol
- ☐ Ulcer
- ☐ Hepatitis
- ☐ HIV
- ☐ Respiratory disease
- ☐ Blood disease
- ☐ Shortness of breath
- ☐ Acid Reflux
- ☐ Auto-Immune Disease
- ☐ Depression
- ☐ Mental Health Disorder

Specify:_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis of any treatment or examination rendered to me or my child during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or Parent if a Minor) Date

WHOLE TREE DENTISTRY

Where Health, Function & Beauty Come Together in a Smile

ADULT SLEEP & BREATHING QUESTIONNAIRE

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Male☐ Female☐

Have you ever had a sleep test administered? Yes☐ No☐

If yes - when did you have your last sleep test? _____

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

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? Yes☐ No☐

Are you happy with your CPAP or Sleep Appliance? Yes☐ No☐

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula:

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

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____