PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Date ____________________

Patient's Name ______________________________ Age ________ Patient's Birthday ________ ☐ Male ☐ Female
Last First Initial

If patient is a minor, give name of parent or legal guardian ______________________________ Relationship ____________

Residence Address ______________________________ For how long? ____________
Street City Zip

Res. Phone ____________ Cell Phone ____________ Email ____________

Patient is ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor Social Security Number ____________

Employed by ____________ How long? ____________ Occupation ____________

Business Address ______________________________ Bus. Phone ____________
Street City Zip

Spouse's Name ____________ Employed by ____________

Address ______________________________

Cell Phone ____________ Email ____________

Occupation ____________

Name of nearest relative not living with you: ____________ Relationship ____________

Name of Physician ____________ Address ____________ Phone ____________ ☐ I have no physician

Former Dentist ____________ Address ____________ Phone ____________

Why are you changing dentists? ____________ Do you wish to speak to the doctor privately? ☐ Yes ☐ No

Purpose of Appointment ______________________________

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: ____________

Whom may we thank for referring you? ____________

FINANCIAL INFORMATION

Person responsible for this account ____________ Relationship ____________ Res. Phone ____________

Residence Address ______________________________ Cell Phone ____________
Street City Zip

Primary Insurance Company ____________ Insured Person's Name ____________

Birthdate ____________ Relationship ____________ Social Security Number ____________

Name of Group Dental Plan ____________ Group No. ____________ Plan No. ____________

Name of Union ____________ Local ____________

Secondary Insurance Company ____________ Insured Person's Name ____________

Birthdate ____________ Relationship ____________ Social Security Number ____________

Name of Group Dental Plan ____________ Group No. ____________ Plan No. ____________

Name of Union ____________ Local ____________

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 of the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collection from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. **Assignment of Insurance:** I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balanced on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/ or his staff, 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 billed unless objected to by me, in writing, within the time of payment thereof. Additionally, I agree that a waiver for any breach of any term of condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/pr collection fees.

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

I have read the above conditions of treatment and agree to its content:

Signed ______________________________ Date ____________

HEALTH QUESTIONNAIRE

These questions are for your benefit and to assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: are you alive? .... (Yes)/No

MEDICAL HISTORY

1. Are you in good health? .... Yes/No
2. Date of last physical examination ________
3. Are you now under the care of a physician? .... Yes/No
   If so, what is the condition being treated? ________
4. Have you ever had any serious illness or operation? .... Yes/No
   If so, what was the operation? ________
5. Have you ever been hospitalized? .... Yes/No
   When ________ If so, what was the problem? ________
6. Are you taking any ☐ medications ☐ drugs ☐ herbs? Yes/No
   List what Meds/Herbs/Drugs being used **and** dosage ________
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? .... Yes/No
   If so, what? ________
8. Have you ever been pre medicated with antibiotics for your dental treatment? .... Yes/No
9. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ other .... Yes/No
10. Do you have or have you had any of the following: (please circle 'Y' for Yes or 'N' for No – answer all conditions):

Y N Anemia
Y N Herpes
Y N Stroke
Y N Ulcers
Y N Diabetes
Y N Arthritis
Y N Asthma
Y N Cancer
Y N Seizures
Y N Hay Fever
Y N Headaches
Y N Implant(s)
Y N Glaucoma
Y N Tonsillitis
Y N Hemophilia
Y N Cold Sores
Y N Emphysema
Y N Rheumatism
Y N Chicken Pox
Y N Bruise Easily
Y N Head Injuries
Y N Heart Failure
Y N Scarlet Fever
Y N Sinus Trouble
Y N Sleep Apnea
Y N Snoring
Y N Heart Murmur
Y N Liver Disease
Y N Blood Disease
Y N Heart Ailments
Y N Heart Attack
Y N Cerebral Palsy
Y N Drug Addiction
Y N Thyroid Disease
Y N Kidney Disease
Y N Chemotherapy
Y N Stomach Ulcers
Y N Angina Pectoris
Y N Artificial Prosthesis
Y N Sickle Cell Disease
Y N Cortisone Medicine
Y N Allergies to Metals
Y N Excessive Bleeding
Y N Mitral Valve Prolapse
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Fainting Spells
Y N Rheumatic Fever
Y N HIV Related Complex
Y N Tuberculosis (TB)
Y N Respiratory Disease
Y N Epilepsy or Seizures
Y N Mental Disorder
Y N Psychiatric Treatment
Y N Hepatitis or Jaundice
Y N Blood Transfusion
Y N Low Blood Sugar
Y N Joint Replacement
Y N Nervous Disorders
Y N Tumors or Growths
Y N Allergies or Hives
Y N Difficulty Swallowing
Y N Congenital Heart Lesions
Y N Osteoporosis
Y N X-Ray or Cobalt Treatment
Y N Pain in Jaw Joints
Y N Radiation Treatment of any kind
Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N TMJ (Temporomandibular Joint) Disorder
Y N Other/ Family Systemic Conditions: ________

11. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes/No
    If so, what? ________
12. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes/No
13. Do you smoke? If yes, how much (per day)? ________ ☐ Cigarettes ☐ Cigars ☐ Packs .... Yes/No
14. Have you ever taken the drugs ☐ Fen-phen ☐ Redux ☐ Fosamax (Bisphosphonate) ☐ Zometa ☐ Actonel ☐ Boniva ☐ Aredia ☐ Diet Drugs? .... Yes/No
15. (Women) Are you pregnant? If so, how many months? ________ .... Yes/No
16. (Women) Do you have any problems associated with your menstrual period? .... Yes/No
17. (Women) Do you take any birth control medication or hormones? .... Yes/No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes/No
2. Have you ever had any unfavorable reactions from a local anesthetic? .... Yes/No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes/No
   If so, explain? ________
4. How long since your last full mouth X-rays? ________ Weeks ________ Months ________ Years
5. How long since your last dental treatment? ________ Weeks ________ Months ________ Years
6. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely .... Yes/No
7. Would you desire to be pre-sedated? .... Yes/No

☐ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way. ☐ Patient refused/ was unable to sign because ________

☐ I have received a copy of the **Dental Materials Fact Sheet** as required by law. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Ⓐ Date ________ **Signature** ________

Ⓑ UPDATE – Since your last visit Ⓐ:

1. Have you seen a medical doctor? .... Yes/No
2. Have you had a change in your medication? .... Yes/No
3. Have you had a change in your medical condition or had surgery? .... Yes/No

Please note changes in health since last visit. If no changes, please write "None" and Date/Sign:

____

Date ________ **Signature** ________

Ⓒ UPDATE – Since your last visit Ⓑ:

1. Have you seen a medical doctor? .... Yes/No
2. Have you had a change in your medication? .... Yes/No
3. Have you had a change in your medical condition or had surgery? .... Yes/No

Please note changes in health since last visit. If no changes, please write "None" and Date/Sign:

____

Reviewed by ________ Lic. # ________ Date ________

REVIEWED BY ***DO NOT WRITE IN THIS SPACE***

Ⓐ ________
DATE ________
Ⓑ ________
DATE ________
Ⓒ ________
DATE ________

	Ⓐ	Ⓑ	Ⓒ
DATE	____	____	____
B.P.	__/__	__/__	__/__
Pulse	____	____	____
By	____	____	____

Date ________ **Signature** ________ ***HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!***

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics, and/or drugs. All services are rendered and accepted under the terms and conditions printed on the reverse hereof: Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed ________ Date ________ Relationship to Patient ________

Personalized Smile Evaluation

Name: ______________________________

Date: ______________

Please take a moment to look at your teeth and gums carefully, and then answer the following questions:

1. On a scale of 1 to 10 (10 being the best rating), how do you feel about your teeth and smile? ______

2. Are your teeth crooked or crowded, and is that a concern?

   ____

3. Do you have any spaces between your teeth that bother you?
   a. Yes b. No

4. Do you like the color of your teeth?
   a. Yes b. No
   Comment: ________________________________

5. Do you like the shape of your teeth?
   a. Yes b. No
   Comment: ________________________________

6. What would you like to change about the appearance of your teeth or smile?

   ____

   ____

   ____

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Tell Us About You…

We want to understand you to better serve your individual needs. Please consider the scale below and place a mark to indicate your opinion or preference. Thank you.

I know a great deal about my dental condition.	I-----I-----I-----I-----I	I know very little about my dental condition.
I like to have only a few options.	I-----I-----I-----I-----I	I like to consider more options.
I tend to look at details.	I-----I-----I-----I-----I	I tend to look at the big picture.
I would prefer long lasting solutions even if more costly.	I-----I-----I-----I-----I	I would prefer more short-term option if it saves money.
I prefer to wait until I must act.	I-----I-----I-----I-----I	I see no reason to delay care.
I understand the cause of Periodontal (Gum and Bone) Disease and my role in its Prevention.	I-----I-----I-----I-----I	I have concerns about Periodontal Disease.
I am pleased with my smile.	I-----I-----I-----I-----I	I find myself covering my smile at times.

In thinking about your previous dental care…

>What have you experienced before that you would hope to find in our office?

>What experiences would you like to avoid?

What are the time, money or other considerations you will want us to understand?

Are there any parts of dental care or your teeth and mouth that frustrate you?

Is there anything else we should know in order to work most effectively with you?

TOOMIN & BIEBER
AESTHETIC COMPREHENSIVE DENTISTRY

Dental Sleep Screener

Name	DOB	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 with shortness 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 ONLY

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

Visual Indications: Mallampati Class_____ Neck Size_____

☐ Enlarged/Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate ☐ Bruxism
☐ Gastroesophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather
Bags under eyes ____ Obesity ____

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No
Are you currently using a CPAP machine? ☐ Yes ☐ No (if yes) Do you use it every night? ☐ Yes ☐ No

Notes:

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