**** Whom may we thank for referring you to our office**?_____
☐ Website ☐ Mailing ☐ Friend _____ ☐ Ins. Plan ☐ Word of Mouth

Patient Information

Patient Name: _____ Da
Last First MI (Preferred Name)

Address:

_____
Street Apartment #

_____
City State Zip Code

Birth Date: _____ Gender: Male _____ Female _____ Family Status: Married ___Single ____Child ___Other ___

Social Security #: _____ Drivers License #_____

Occupation_____ Best time to call: AM PM

Phone (Home):_____(Work):_____ Ext: _____(Cellular or Beeper)_____-_____

E-Mail Address _____

Who should be notified in case of emergency?_____Phone#_____
How do you prefer to be contacted? ☐Phone home/cell ☐Text message ☐E-mail _

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐Tu ☐W ☐Th ☐ Fr

Consent for Services

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

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

_____ Date: _____ Relationship to Patient:

Signature of patient, parent or guardian

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

Social Security #: _____ Birth Date:

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

Address: _

_____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name:_____ Occupation:

_____

Address: _____

_____
Street City , State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ SS #: _____ Group #:

Insurance Company:

Name Street City State Zip Code

Insured's Employer Name:

Address:

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ SS #: _____ Group #:

Insurance company:

Name Street City State Zip Code

Insured's Employer Name:

Address:

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental History
Last Dental Visit_____

Reason for today's visit_____

Are any of your teeth yellow, stained or somewhat discolored?	Yes	No
Would you like your teeth to be whiter?	Yes	No
Do you have any gaps or spaces between your teeth?	Yes	No
Are any of your teeth turned, crooked, or uneven?	Yes	No
Are you missing any teeth?	Yes	No
Do you see any pitting or defects on the surfaces of your teeth?	Yes	No
Are the edges of any teeth worn down, chipped or uneven?	Yes	No
Do any of your teeth appear too small, short, large or long?	Yes	No
Do you have any prior dental work that appears unnatural?	Yes	No
Do you have a "gummy" smile (too much of your gums show when smiling)?	Yes	No
Are your gums red, sore, puffy, bleeding or receded?	Yes	No
Are you self-conscious about your teeth or smile?	Yes	No
Would you like to change anything about the appearance of your teeth or smile?	Yes	No

Comments_____

Medical History

- 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:

_____

- Are you taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Are you Allergic to anything? ☐ Yes ☐ No
  If yes, please list: _____
- Women: Are you Pregnant? ☐ Yes ☐ No Week_____ : Are you Breast Feeding ☐ Yes ☐ No

Please circle any of the following conditions that apply to your health:

Asthma	Anxiety	Anemia	Artificial Joints
Blood Disorders	Cancer	Diabetes	Epilepsy/seizures
Excessive Bleeding	Fainting	Glaucoma	Heart Disease
High Blood Pressure	Hay Fever	Heart Murmur	Hepatitis A/ B/ C
HIV (AIDS)	Kidney Disease	Liver Disease	Lung Disease
Mental Disabilities	Osteoperosis	Pacemaker	Psychiatric Treatment
Radiation Therapy	Rheumatic Fever	Sinusitis	Stroke
Stomach Problems	Thyroid hypo/hyper	Tumors	Tuberculosis

Other_____

Please Elaborate on anything you circled: _____

_____

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

- **Obstructive Sleep Apnea Screening**
- **S (snore)**
  Do you snore? ☐ Yes ☐ No
- **T (tired)**
  Do you feel fatigued during the day? ☐ Yes ☐ No
  Do you wake up feeling like you haven't slept? ☐ Yes ☐ No
- **O (obstruction)**
  Have you been told you stop breathing at night? ☐ Yes ☐ No
  Do you gasp for air or choke while sleeping? ☐ Yes ☐ No
- **P (pressure)**
  Do you have high blood pressure or are on medication to control high blood pressure? ☐ Yes ☐ No

SCORE: If you checked YES to two or more questions on the STOP portion you are at risk for OSA.

- **B (BMI)**
  Is your body mass index greater than 28? ☐ Yes ☐ No
- **A (age)**
  Are you 50 years old or older? ☐ Yes ☐ No
- **N (neck)**
  Are you a male with neck circumference greater than 17 inches, or a female with neck circumference greater than 16 inches? ☐ Yes ☐ No
- **G (gender)**
  Are you a male? ☐ Yes ☐ No

SCORE: The more questions you checked YES to on the BANG portion, the greater your risk of having moderate to severe OSA.