Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: _____

Social Security #: _____ Driver's License # _____ State _____

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

(Cell) _____ E-Mail: _____ Fax: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores/Fever Blisters
- ☐ Contact Lenses
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Diet (Special/Restricted)
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ H. I. V. Positive
- ☐ Head Injuries
- ☐ Heart (Attack, Disease, Surgery
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Psychiatric/Psychological Care
- ☐ **Pregnancy**
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoke/Chew Tobacco
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Allergic/Adverse Reaction To Medication or Any Substance, Please specify:
  _____
  _____
- ☐ Other: _____

- 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: _____
- Do you have any health problems that need further clarification? ◯ Yes ◯ No
  If yes, please explain: _____
- Are you taking any medications? Please list _____

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 doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Doctor

Dental Information

Is there anything about your smile that you do not like?_____

Are you interested in knowing the options available for a more beautiful smile?_____

Do you like the appearance of your teeth?_____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting?_____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with?_____

What would you like to change the most about the appearance of your teeth?_____

_____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor ☐ Dental Office

☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

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: _____ Driver's License #_____

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

Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Telephone: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

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

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

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

EPWORTH SLEEPINESS SCALE

Name_____ DOB_____

Date _____ Gender_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

It is important that you answer each question **as best** as you can.

Situation	**Chance of dozing** (out of 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. a theatre 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	
Total out of 24	

Score Interpretation:

(1-10) Normal Range (10--16) Excessively sleepy (16-24) Abnormally sleepy

Sleep, Breathing & Habit Questionnaire

Children & Adolescents

Full Name:	Age:	Date:

Please indicate if your child experiences or has experienced any of these symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence **1 - Occurs Rarely** **2 - Occurs 2 to 4 times per week** **3 - Occurs 5 to 7 times per week**

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bed wetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Seasonal allergies
18. _____ Ear infections of history of ear infections
19. _____ Short attention span
20. _____ Trouble focusing
21. _____ Difficulty listening/ often interrupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech issues*
28. _____ Avoidance behavior towards food or certain types of food

***Speech Questionnaire -** to be filled out only if #27 was indicated above

Please check all that apply

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Other have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Liquids and/or solids get into nasal area when eating or drinking?

EPWORTH SLEEPINESS SCALE

Name _____ DOB _____

Date _____ Gender _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

It is important that you answer each question **as best as you can.

Situation	Chance of dozing (out of 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. a theatre 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	
	Total out of 24

Score Interpretation:

(1-10) Normal Range (10–16) Excessively sleepy (16-24) Abnormally sleepy

Name:_____ Date:_____

HEADACHE IMPACT TEST™

Please circle the response that best describes how you feel and calculate the totals below.

1. **When you have headaches, how often is the pain severe?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

2. **How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

3. **When your have a headache, how often do you wish you could lie down?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

4. **In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?**

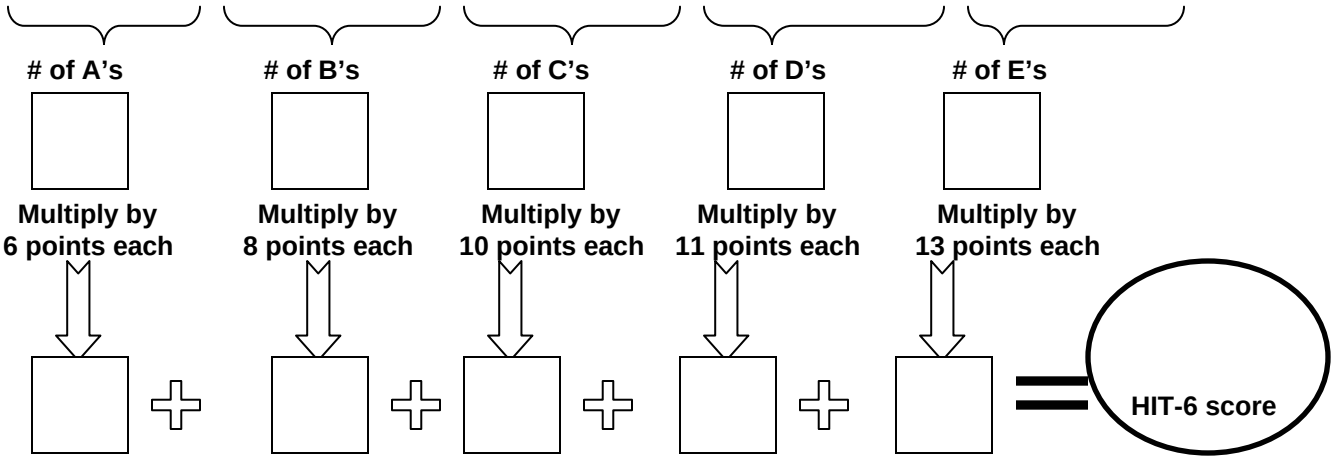
A) Never B) Rarely C) Sometimes D) Very Often E) Always

5. **In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

6. **In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always



Bonus Questions

On a scale of 0-10, with "10" being the worst discomfort imaginable above the shoulders, and a "0" is no pain at all (you feel fabulous), how many mornings per week do you wake with a "0", that is, *you feel fabulous?*_____

On those mornings that you wake "with a number", what's the average number that you have? _____

HEADACHE IMPACT TEST™

What Does Your Score Mean?

If You Scored 60 or More

Your headaches are having a very severe impact on your life. You may be experiencing disabling pain and other symptoms that are more severe than those of other headache sufferers. Don't let your headaches stop you from enjoying the important things in your life, like family, work, school or social activities.

Make an appointment **today** to discuss your HIT-6 results and your headaches with your doctor.

If You Scored 56 – 59

Your headaches are having a substantial impact on your life. As a result you may be experiencing severe pain and other symptoms, causing you to miss some time from family, work, school, or social activities.

Make an appointment **today** to discuss your HIT-6 results and your headaches with your doctor.

If You Scored 50 – 55

Your headaches seem to be having some impact on your life. Your headaches should not make you miss time from family, work, school, or social activities.

Make sure you discuss your HIT-6 results and your headaches at your next appointment with your doctor.

If You Scored 49 or Less

Your headaches seem to be having little to no impact on your life at this time. We encourage you to take HIT-6 monthly to continue to track how your headaches affect your life.

If Your Score on HIT-6 is 50 or Higher

You should share the results with your doctor. Headaches that are disrupting your life could be migraine.

Take HIT-6 with you when you visit your doctor because research shows that when doctors understand exactly how badly headaches affect the lives of their patients, they are much more likely to provide a successful treatment program, which may include medication.

HIT is also available on the Internet at www.headachetest.com.

The Internet version allows you to print out a personal report of your results as well as a special detailed version for your doctor.

Don't forget to take HIT-6 again or try the Internet version to continue to monitor your progress.

About HIT

The Headache Impact Test (HIT) is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36®* health assessment tool.

HIT is not intended to offer medical advice regarding medical diagnosis or treatment. You should talk to your healthcare provider for advice specific to your situation.

HIT-6 Scoring Interpretation English Version 1.1