

DREW DENTAL

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Family | Cosmetic | Invisalign | Implants

PLEASE PRINT

Date _____

Patient Name _____ Sex: M F Birthdate _____
First MI Last

Single Married Partner Widowed Dependent Child Email _____

Address _____
City State Zip

Phone Home _____ Work _____ Cell _____ Referred by: _____
Emergency contact: _____ Phone _____ Relationship _____
(Friend or relative not living with you)

Physician or Clinic _____ Phone _____ Date of Last Medical Exam _____

Previous dentist: _____ Phone #: _____ When was your last dental treatment? _____

Pharmacy (we can use to call in medication): _____ Premedication needed for dental appointments? _____

I give my consent to use local anesthetic, or relaxants for completing necessary dental treatment.

Signed _____ Date _____
(parent if child is minor)

I, _____ have received a copy of the **DENTAL MATERIALS FACT SHEET**.
(please print name)

Patient Signature (parent if minor) _____ Date: _____

I understand I will also receive and acknowledge a copy of the Drew Dental privacy policy

Is there anything you would like us to know about your dental health or previous dental treatment? How we can help you today? _____

How do you feel about the appearance of your teeth?

Dental Information

Are you in dental discomfort today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you missing any teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have they been replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums bleed when you floss or brush?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent "tension" headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been treated by a periodontist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear a nightguard?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of your teeth sensitive to:	<input type="checkbox"/> Hot? <input type="checkbox"/> Cold? <input type="checkbox"/> Sweets? <input type="checkbox"/> Pressure		

Medical History

Height _____ Weight _____

Yes No

- Substance abuse
- Heart murmur/trouble
- Heart or chest pain
- Rheumatic fever
- Pacemaker
- Prosthetic valve
- Sinus problems
- High blood pressure
- Low Blood Pressure
- Recent cough or cold
- Facial radiation therapy
- Fibromyalgia
- Sleep Apnea
- Mouth Breathing

Yes No

- Lung disease
- Cancer
- Asthma
- Bronchitis
- Diabetes
- Kidney disease
- Liver disease
- Hepatitis
- Convulsions/epilepsy
- Nose obstruction
- Cortisone or ACTH
- GERD
- Atrial Fibrillation
- Morning Headaches

Yes No

- Thyroid condition
- Bleeding tendency
- Anemia
- Surgical implant
- Joint Replacement
- Venereal disease
- HIV positive
- Herpes
- Psychiatric treatment
- Headaches or ear pains
- High Cholesterol
- Acid Reflux
- Stroke
- Daytime Sleepiness

Allergy or unusual reaction to:

Yes No

- Penicillin
- Clindamycin
- Sulfa
- Azithromycin
- Aspirin
- Milk
- Ibuprofen
- Valium/Halcion/Xanax
- Other Drugs _____

Yes No

- Latex
- Epinephrine
- Novocaine
- Norco/Vicodin
- Codeine
- Nitrous
- Acetaminophen

Do you take anticoagulants / blood thinners? (incl. daily aspirin) Yes No explain _____

Have you ever had excessive bleeding requiring special treatment? Yes No explain _____

Have you ever taken bisphosphonates? Yes No such as zoledronate, pamidronate, fosamax, boniva, actonel

Do you take Supplements? Yes No explain _____

Do you use Sleep Aids? Yes No explain _____

Have you been told you snore or stop breathing at night? Yes No explain _____

Have you been diagnosed with Sleep Apnea? Yes No explain _____

Do you wear a CPAP? Yes No Have you in the past? Yes No Have you been told to? Yes No _____

Have you had a Sleep Study or been told to get a Sleep Study? Yes No _____

Are you now taking any medications? Yes No **Please list all medications:** _____

Do you smoke? Yes No If yes how much? _____ pack(s) per day

Do you get short of breath easily? Yes No explain _____

Must you sleep with your head on more than one pillow? Yes No explain _____

Have you ever fainted? Yes No explain _____

Have you ever had general anesthesia? Yes No explain _____

Have you been hospitalized within the last 5 years? Yes No explain _____

Are you under the care of a physician? Yes No explain _____

Have you ever responded unfavorably to medical or dental care? Yes No explain _____

Do you like to use Nitrous Oxide for dental visits? Yes No explain _____

Do you like to use oral sedation for your dental treatment? Yes No Available options: Halcion, Valium, Xanax

Any medical condition or problems not listed above? Yes No explain _____

Women only: Pregnant? Yes No Breast feeding? Yes No Birth control pills? Yes No

What is your delivery date?: _____ OB Dr. _____

Patient Signature _____ Date _____ Provider Signature _____

Updates

Changes: Yes/No? Signature _____ Date _____ Provider _____

Changes: Yes/No? Signature _____ Date _____ Provider _____

Changes: Yes/No? Signature _____ Date _____ Provider _____

Financial Responsibility

Guarantor name: _____ DOB _____

Address: _____ St: _____ Zipcode: _____

SS# _____ Employer: _____

Hm Phone _____ Cell Phone _____ Work Phone _____

Patient Name: _____

Dental Insurance

Primary Dental Insurance

Patient's relationship to insured: Self Spouse Child

Subscriber: _____ DOB: _____

Group# _____ Employer name: _____

SS#/Member ID: _____

Insurance: _____ Insurance Phone Number: _____

Secondary Dental Insurance

Patient's relationship to insured: Self Spouse Child

Subscriber: _____ DOB: _____

Group# _____ Employer: _____

SS#/Member ID: _____

Insurance: _____ Phone Number: _____

Please provide a copy of your dental card(s)

I understand that I am financially responsible for all charges, including any amount not covered by insurance.

For accounts with insurance billing: Due to increased use of electronic claims, a permanent record of the patient's assignment of benefits is required. Please read and sign below. Thank you. I accept treatment as noted and authorize release of information relating hereto. I hereby authorize payment directly to the dentist named on the attached claim of the group insurance benefits otherwise payable to me.

Guarantor Signature _____ Date _____

Drew Dental Sleep Screening Questionnaire

There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name: _____ **Height:** _____ **Weight:** _____

Date: _____ **Age:** _____ **PCP:** _____

Epworth Sleepiness Scale

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

- | | |
|---|---|
| 0 = I would never doze | 2 = I have a moderate chance of dozing |
| 1 = I have a slight chance of dozing | 3 = I have a high chance of dozing |

Situation

Chance of Dozing

- | | |
|---|-------|
| 1. Sitting and reading | _____ |
| 2. Watching TV | _____ |
| 3. Sitting inactive in a public place (e.g. a theater or a meeting) | _____ |
| 4. As a passenger in a car for an hour without a break | _____ |
| 5. Lying down to rest in the afternoon when circumstances permit | _____ |
| 6. Sitting and talking to someone | _____ |
| 7. Sitting quietly after lunch without alcohol | _____ |
| 8. In a car while stopped for a few minutes in traffic | _____ |

Total Score _____

Have you ever been diagnosed with:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Impaired Cognition (i.e. difficulty concentrating or thinking) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Mood Disorders/Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Insomnia | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Hypertension (high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Sleep Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes: Did you try to use CPAP | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. TMJ problems significant enough to require treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Gastric Reflux (GERD) or Heartburn | <input type="checkbox"/> | <input type="checkbox"/> |

Are you aware of (or have you been told):

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Snoring on a regular basis | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Feeling tired or fatigued on a regular basis | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Clenching or grinding your teeth (bruxism) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Having frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Your neck size being > 17 inches (male) or > 16 inches (female) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Anyone in your family having sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Stopping breathing when sleeping/awakening with a gasp | <input type="checkbox"/> | <input type="checkbox"/> |

For children only (filled out by parent or guardian)

Are you aware of your child:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Snoring/noisy breathing while sleeping | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Grinding his or her teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Wetting the bed | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Having difficulty in school/learning | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Being treated for ADD or ADHD | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Breathing primarily through their mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Having frequent nightmares/night terrors | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Having frequent ear aches | <input type="checkbox"/> | <input type="checkbox"/> |

Dental Exam Findings: Evidence of Bruxism Scalloping of the tongue Crowded airway
 Tori or Bone Loss Anterior wear Retrognathia / Class II

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____ [full name], have received a copy of the Drew Dental Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program 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)