DREW DENTAL

783 Rio Del Mar Blvd. Aptos, CA 95003 831.688.6060 info@drewdental.com
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_____
Patient Signature (Parent or Guardian)

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

Patient Signature (Parent or Guardian)_____Date:_____

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

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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?	❑ Yes ❑ No	Have you ever had orthodontic treatment?	❑ Yes ❑ No
Are you missing any teeth?	❑ Yes ❑ No	Do you grind your teeth?	❑ Yes ❑ No
Have they been replaced?	❑ Yes ❑ No	Do you clench your teeth?	❑ Yes ❑ No
Do your gums bleed when you floss or brush?	❑ Yes ❑ No	Do you have frequent "tension" headaches?	❑ Yes ❑ No
Have you been treated by a periodontist?	❑ Yes ❑ No	Do you wear a nightguard?	❑ Yes ❑ No

Are any of your teeth sensitive to: ❑ Hot? ❑ Cold? ❑ Sweets? ❑ Pressure

Medical History

Height _____ Weight _____

Yes No	Yes No	Yes No
❑ ❑ Substance abuse	❑ ❑ Lung disease	❑ ❑ Thyroid condition
❑ ❑ Heart murmur/trouble	❑ ❑ Cancer	❑ ❑ Bleeding tendency
❑ ❑ Heart or chest pain	❑ ❑ Asthma	❑ ❑ Anemia
❑ ❑ Rheumatic fever	❑ ❑ Bronchitis	❑ ❑ Surgical implant
❑ ❑ Pacemaker	❑ ❑ Diabetes	❑ ❑ Joint Replacement
❑ ❑ Prosthetic valve	❑ ❑ Kidney disease	❑ ❑ Venereal disease
❑ ❑ Sinus problems	❑ ❑ Liver disease	❑ ❑ HIV positive
❑ ❑ High blood pressure	❑ ❑ Hepatitis	❑ ❑ Herpes
❑ ❑ Low Blood Pressure	❑ ❑ Convulsions/epilepsy	❑ ❑ Psychiatric treatment
❑ ❑ Recent cough or cold	❑ ❑ Nose obstruction	❑ ❑ Headaches or ear pains
❑ ❑ Facial radiation therapy	❑ ❑ Cortisone or ACTH	❑ ❑ High Cholesterol
❑ ❑ Fibromyalgia	❑ ❑ GERD	❑ ❑ Acid Reflux
❑ ❑ Sleep Apnea	❑ ❑ Atrial Fibrillation	❑ ❑ Stroke
❑ ❑ Mouth Breathing	❑ ❑ Morning Headaches	❑ ❑ Daytime Sleepiness

Allergy or unusual reaction to:

Yes No	Yes No
❑ ❑ Penicillin	❑ ❑ Latex
❑ ❑ Clindamycin	❑ ❑ Epinephrine
❑ ❑ Sulfa	❑ ❑ Novocaine
❑ ❑ Azithromycin	❑ ❑ Norco/Vicodin
❑ ❑ Aspirin	❑ ❑ Codeine
❑ ❑ Milk	❑ ❑ Nitrous
❑ ❑ Ibuprofen	❑ ❑ Acetaminophen
❑ ❑ Valium/Halcion/Xanax	
❑ ❑ Other Drugs_____	

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 oral sedation for your dental treatment? ❑ Yes ❑ No Available options: Halcion, Valium
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_____

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:**_____ **Primary MD:**_____

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
1 = I have a slight chance of dozing
2 = I have a moderate 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)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

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)

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 assignation 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 _____