



Patient Information Form

Name: _____ Nickname: _____
Address: _____ City: _____ State: _____ Zip _____
Home phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Date of Birth: _____ Social Security Number: _____

Responsible Party (if someone other than the patient)

Name: _____
Address: _____
Date of Birth: _____ Social Security Number: _____

Insurance Information

Name of Insured: _____ DOB: _____
Member ID: _____ Group #: _____
Employer: _____
Insurance Company: _____

Address for Claims: _____

Phone Number: _____

Emergency Contact Information

Full Name: _____ Relationship: _____
Contact Phone: _____ Alternate Phone: _____

How did you hear about us? Facebook Google Family/Friend Mira Bay Magazine Drive-By
Other: _____

If you were referred by a current patient, whom may we thank?

Dental History

Reason for today's visit? _____

Name of your last dentist? _____ Date of your last dental visit: _____

What was done at your last dental visit? _____

Why did you leave your last dentist? _____

Out of all the offices locally, what made you choose ours? _____

Has anything kept you from seeing a dentist regularly or getting needed dental work done?

Do you clench or grind your teeth? Yes No Maybe

Are your teeth sensitive to hot/cold? Yes No Sometimes

Are you experiencing pain or discomfort in your teeth? If yes, explain: _____

Are your gums irritated, tender or swollen? If yes, explain: _____

Do your gums bleed? If yes, explain: _____

On average, how many times per week do you floss? 7 6 5 4 3 2 1 rarely never

Have you ever been told you have "gum disease" or need "deep cleanings"? Yes No

Which type of toothbrush do you use? Manual Electric Brand _____

Do you suffer from headaches? If yes, how many times per month? _____

Are you missing any teeth? _____

Do you have a dry mouth? Yes No

In the past, how frequently did you have your preventive dental visits (cleanings)?

 __ 3 months __ 6 months __ 12 months __ 13+months

How important is it to you to have optimal oral health? Not very 1 2 3 4 5 Very

How important is "preventive" dentistry to you? Not very 1 2 3 4 5 Very

How important is it to you to improve your smile? Not very 1 2 3 4 5 Very

Do you have any old filling or previous dental treatment that is no longer satisfactory to you? If yes, please explain _____

Please use the space below and let us know any other concerns you may have, including how we can make your visits meet your needs:

Please check which condition/procedures you would like to learn more about:

__crowded teeth __spaced teeth __improper bite __implants

__grinding/clenching __replace silver fillings __one visit crowns __sealants

__gum disease __gum recession __porcelain veneers __dentures

__wisdom teeth __whiten teeth __partial dentures

Medical History

Patient Name: _____ **Birth Date:** _____

Although dentistry primarily treats the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an impact on the dentistry you will receive.

Please list all medications you are taking, both over the counter and prescription

Name:	For:

Do you have any known allergies to any of the following?

Penicillin
 Codeine
 Aspirin
 Latex
 Acrylic
 Metal
 Other _____

Women: Are you

Pregnant/trying to get pregnant? Yes No
 Taking oral contraceptives? Yes No
 Nursing? Yes No

General:

Do you use tobacco? Yes No How much per day? _____

Have you ever had to take antibiotics before receiving routine dental care? Yes No Why? _____

Have you ever taken a bisphosphonate medicine? (common ones are Fosamax, Actonel, Boniva) Yes No

Do you have, or have you had any of the following?

- | Y N | Y N | Y N | Y N |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives Or Rash | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling Of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Lund Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumors or growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cold sores/Fever blisters | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis | |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatism | |

Have you ever had any serious illness not listed above? Yes No If yes, Please Explain: _____

DoctorsComments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ Date _____

DOCTORS SIGNATURE _____ Date _____

Dental Sleep Screening Questionnaire

Patient Name: _____ **Birth Date:** _____

How likely are you to doze off in the following situations?

0= No chance of dozing

1= Slight chance of dozing

2= Moderate chance of dozing

3= High chance of dozing

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (e.g. theater 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 _____

Add your scores up Total _____

Do you feel you get poor quality sleep? Yes No

Has anyone noticed if you quit breathing during your sleep? Yes No

Do you ever wake up in the night snorting or gasping for air? Yes No

Have you ever been diagnosed with sleep apnea? Yes No

Do you have a CPAP machine? Yes No

If yes, on average how many nights/wk do you wear it? _____ nights

What % of the night do you wear it? _____ % of the night

Do you snore? Yes No

Has anyone ever told you that you snore? Yes No

Are you interested in hearing more about dental appliances which can eliminate snoring for either you or your bed partner? Yes No

Financial and Appointment Policies

Thank you for choosing our office for your dental needs. Our practice offers various payment and financial options to meet our patient's needs. As a courtesy, we will gladly assign payments for dental treatment from your insurance company directly to our office. Dental insurance is a contract between you, your employer or plan sponsor, and the insurance company. These contracts vary widely, therefore, we will do our best to estimate the portion your insurance company will pay toward your treatment and process any claims needed. **We cannot guarantee payment from your insurance company and your balance may be different than our estimate. In the event that your insurance company refuses to pay all or a portion of your claim, you will be responsible for payment for your dental treatment.**

Initials

- _____ 1. **Dr. Belof is not contracted with any dental insurance company as an in network provider.** However, most PPO insurances plans will still pay this office.
- _____ 2. You agree that the charges you incur here are **your responsibility regardless of what your insurance company pays or does not pay** toward your treatment.
- _____ 3. **You agree to pay your bill in full if your insurance company had not paid, or underpays for your treatment.** You understand that your insurance company may ask for additional information and we will provide this information upon request. If for any reason there is an overpayment on your account, a refund check, or credit on your credit card, will be sent.
- _____ 4. **You agree that we are not responsible for knowing the various scenarios in which your insurance does not pay services.** Such scenarios include preexisting conditions, waiting periods, x-rays which can only be paid on every so often, less costly alternatives, required pre-authorizations, etc. Your insurance can use these and other reasons to avoid paying your claim. We will try to provide you with as much information as possible; however, we will not be responsible for knowing the various intricacies of your particular insurance contract. You will be responsible for knowing your benefits and informing us of any changes.
- _____ 5. **Furthermore, we reserve the right to charge a fee for appointments missed without giving at least 48 hours notice, as this time could have been used for other patients.**

I have read and agreed to the above payment policy

Patient Signature: _____ Date _____

Health Insurance Portability and Accountability ACT (HIPAA)

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

I give permission to disclose details of my account, chart, and conditions to the following people.
(The most frequently listed person is the spouse).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____