The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely (please print). The better we communicate, the better we can care for you!

About You

Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Mr. Mrs. Miss Ms. Dr.	Marital Status: Single Mar Div Sep Wid
Prefered Name:		**Birth Date:**	**Age:**	**Sex:** M F / **Spouse's Name:**
Street Address:				**PO Box:**
City:	**State:**	**Zip Code**		**Email Address:**
Home Phone:	**Cell Phone:**			**Other Phone:**
Occupation:	**Employer:**			**Employer Phone:**

Please take a moment to say how you heard about us:

Doctor: Friend:

Phonebook Seminar Newspaper TV Commercial Radio Facebook Internet/Website

Other family members seen here:

BILLING INFORMATION

Full payment is expected at time of service, unless prior financial arrangements have been made. As a courtesy we will file your insurance claim and request that reimbursement be remitted directly to you. Please give your insurance card and driver's license to the receptionist to copy for your file.

Person responsible for bill:	Birth date:	Address (if different):	Home phone #:

Is this person a patient here? Yes No Occupation:

Employer:	Employer address:	Employer phone #:

Subscriber's name:	Birth date:	Subscriber's SSN:	Group #:	Policy #:

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Home phone #: Work Phone #:

Medical/Dental History

MEDICAL HISTORY

Do you consider your current physical health to be: Good Fair Poor

Do you have a personal physician? No Yes

Physician's Name: Phone #

Are you currently under the care of the above or any other physician? No Yes (explain below)

Have you ever had to pre-medicate with antibiotics prior to dental treatment? No Yes

If yes, please list what type of antibiotics you take:

Have you ever had any of the following problems and/or conditions?

N	Y		N	Y		N	Y	
		Alzheimer's			Emphysema			Mitral Valve Prolapse
		Anemia			Epilepsy/Seizures			Pacemaker
		Arthritis			Fever Blisters			Parkinson's Disease
		Artificial Bones/Joints			Glaucoma			Psychiatric Problems
		Artificial Valves			Heart Attack			Radiation Treatment
		Asthma			Heart Disease			Rheumatic Fever
		Blind			Heart Murmur			Rheumatism
		Blood Transfusions			Hemophilia			Severe Headaches
		Cancer			Hepatitis			Sinus Problems
		Chemotherapy			HIV / AIDS			Stroke
		Colitis			High Blood Pressure			Thyroid
		Congenital Heart Defect			Hospitalized recently			Tuberculosis (TB)
		Deaf			Internal Defibrillator			Ulcers/Stomach Problems
		Diabetes			Kidney Problems			
		Drug/Alcohol Abuse			Low Blood Pressure			

For Women: Are you taking birth control pills? No Yes Pregnant? No Yes Nursing? No Yes

Are you allergic to any of the following? No Yes, Please indicate below:

Aspirin	Codeine	Epinephrine	Erythromycin	Ibuprofen
Iodine	Penicillin	Sulfa	Tetracycline	Latex

Please list any other allergies here:

Please list any other serious illnesses you have had, or conditions not listed above:

Are you taking any blood thinners or aspirin? No Yes, list here:

Please list any medications not listed above that you are currently taking including any over the counter medications, or attach a complete list. Please also include medications for cancer treatment, herbal or natural supplements, or weight loss supplements that you are now taking *or have taken in the past:*

Medication:	Dosage:	Frequency:
Medication:	Dosage:	Frequency:
Medication:	Dosage:	Frequency:
Medication:	Dosage:	Frequency:
Medication:	Dosage:	Frequency:

Medical/Dental History

DENTAL HISTORY

What is the reason for your visit today?

What is the name of your Previous or Present Dentist:

Date of last dental visit:	Date of last hygiene (cleaning):	Date of last full mouth x-rays:

Do you consider your current dental health to be: Good Fair Poor

How often do you brush your teeth?	How often do you floss your teeth?

Type of toothbrush: Soft Medium Hard Electric Manual

What products do you use? Waterpik Sulcabrush Proxi-Brush Sonicare Oral-B

How often are your hygiene visits: 3 Months 4 Months 6 Months 1 Year

Do you currently have any dental problems? No Yes, please explain below:

APPEARANCE OF TEETH

No Yes Are you satisfied with your teeth's appearance and/or smile?

No Yes Would you like to keep all of your teeth all of your life?

PAST DENTAL EXPERIENCE

No Yes Do you feel nervous about dental treatment? If so, what is your biggest concern?

No Yes Have you ever had serious/difficult problems associated with any previous dental work or had an upsetting dental experience? If yes, please explain below:

Are your teeth sensitive to: Hot or Cold? No Yes Sweets? No Yes

Are your teeth sensitive to: Biting or Chewing? No Yes

No Yes Have you ever noticed any mouth odors?

No Yes Do you frequently get cold sores, blisters, or other lesions?

No Yes Do your gums bleed or hurt?

No Yes Have you experienced gum disease or tooth loss?

No Yes Have you noticed any loose teeth or change in your bite?

No Yes Do you hold foreign objects with your teeth, such as pens, pins, a pipe, nails, etc...?

No Yes Do you breathe through your mouth while awake or asleep?

No Yes Do you have tired jaws, especially in the morning?

No Yes Does food tend to get caught between your teeth? If Yes, where?

No Yes Do you smoke? No Yes Do you chew tobacco?

HAVE YOU EVER HAD:

No Yes Pain in the jaw joint, ear, or side of face?

No Yes Difficulty in opening or closing the mouth?

No Yes Difficulty in chewing on either side?

No Yes Headaches, neck aches, or shoulder aches?

No Yes Sore muscles in the neck and/or shoulders?

Section 1 : Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) - Check one box only

	0	1	2	3
Sitting and reading				
Watching television				
Sitting in a public place				
As a passenger in a car for one hour				
Driving a car stopped for a few minutes in traffic				
Sitting and talking to someone				
Sitting down quietly after lunch without alcohol				
Lying down to rest in the afternoon				

Section 2: Patient Evaluation

Fill in the blanks. Check Yes or No for each question

	NO (0)	YES (1)
BMI (See Chart in Office) : ___________ Is it greater than or equal to 30?		
Neck Circumference: ___________ Is is greater than 17" (men) or 15" (women)?		
Have you gained at least 15 lbs in the past 6 months?		

Section 3: Subjective Sleep Evaluation

Please check Yes or No for each question

	NO (0)	YES (1)
Do you snore?		
Would you or your spouse consider your snoring louder than a person talking?		
Does your snoring occur almost every night?		
Is your snoring bothersome to your bed partner?		
Do you feel that in some way your sleep is not refreshing or restful?		
Do you wake up at night or in the mornings with headaches?		
Do you experience fatigue during the day and have difficulty staying awake?		
Do you have trouble remembering things or paying attention during the day?		
Do you have high blood pressure?		

Section 4: Prior Diagnosis

Please check Yes or No for each question

	NO (0)	YES (1)
Have you ever been diagnosed with sleep apnea?		

If Yes:

When were you diagnosed (Approximate) Month: Year:

	NO (0)	YES (1)
Were you put on CPAP Therapy for treatment?		
Are you still using your CPAP every night?		

Notes: Please include any notes on the back of the page for the doctor regarding snoring, sleep pattern, or sleep apnea that you feel may be appropriate

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OFFICE USE ONLY

Total Scores: Section 1: _____ Section 2: _____ Section 3: _____ Section 4: _____

ESS Score ≥ 8? ____ Pt. Eval ≥ 2?____ Subj. Sleep Eval? ≥ 3?____ Prior OSA Diagnosis ≥ 1?____

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also understand that full payment is expected at the time of service, unless prior financial arrangements have been made. As a courtesy we will file your insurance claim and request reimbursement be remitted directly to you. If payment in full is not made at the time of service, I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or to Village Dental. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment.

Patient/Guardian Signature: **Date:**

_________________________________ _______________

Responsible Party (if other than patient): **Date:**

_________________________________ _______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, ___________________________________ have received a copy of Village Dental's Notice of Privacy Policies.

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Please Print Name

_____________________________________ _______________

Signature **Date**

I authorize the following individuals to access my dental records:

For office use 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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other, please specify below: