DENTAL PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date _____

(please print)

Patient Name: _____ Date of Birth: _____

Last Middle First

Address:_____

Street City Apt or Lot # Zip Code

Home Tel#: _____ Work#: _____ Cell#: _____

Social Security#: _____ Marital Status: _____ Sex: F M

Referred By: _____

E-mail: _____ Local Pharmacy#: _____

Dental Insurance: _____ Phone#: _____

Has any member of your immediate family been treated by us before? _____

PARENT INFORMATION (if patient is a MINOR)

Mother's Name: _____ Social Security#: _____

Address: _____ Home#: _____ Cell#: _____

Father's Name: _____ Social Security#: _____

Address: _____Home#: _____Cell#: _____

PATIENT EMPLOYER

Employer's Name: _____Occupation: _____

Employer Address:_____ Phone#: _____

IN CASE OF AN EMERGENCY, WHO DO WE NOTIFY?

Name: _____ Relationship: _____

Address: _____ Phone#: _____

IMPORTANT: How would you like to be contacted? Text_____ E-mail _____ Phone _____

MARITAL STATUS _____ Spouse DOB _____ Spouse SSN _____

Spouse Name _____ Employer _____ Phone #: _____

Insurance Company _____ Policy #: _____

Group #: _____ Insurance Claims Address: _____

HEALTH HISTORY

Name: _____ Date: _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care:_____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following questions, mark yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related	No	Yes	Glaucoma	No	Yes
Emphysema or other	No	Yes	Abnormal Bleeding from	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight	No	Yes
Heart (Surgery, Disease)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	Cancer	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: are you pregnant? No Yes
If no, are you planning a pregnancy in the near future No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? No Yes
If yes, what is it usually? High _____ Low _____

Are you allergic or have you had a reaction to:
a. Local anesthetics No Yes
b. Penicillin or other antibiotics No Yes
c. Aspirin No Yes
d. Codeine, Valium or other sedative No Yes
e. Other _____ No Yes

Are you a smoker? No Yes If so, how much do you smoke per day?_____

Please list any medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you taking any herbal supplements? No Yes If yes, which ones? _____

Diet: Restricted Diet _____
How many meals a day _____
Food allergies _____
Sugar in your diet: none_____ Slight_____ Moderate_____ High_____

Dental History:
Date of last dental check-up_____
Why have you come to the dentist today?_____
Previous dentist_____
Reason for leaving last dentist_____

Do you snore?	No	Yes
Do you sleep through the night?	No	Yes
How many hours on average? _____		
How many times do you wake up? _____		
Short of breath?	No	Yes
Tired through the day?	No	Yes
Ever done a sleep study?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health and medication.

I hereby authorize the doctors of LBHC to perform dental treatment, including the use of any necessary or advisable radiographs or diagnostics aids.

We have recently incorporated an oral cancer screening as standard of care. It is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. This enhanced examination is recognized by the American Dental Association procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is _____.

❒ Yes, I would prefer to have an oral cancer exam at this time.
❒ No, I would prefer not to have an oral cancer exam at this time.

_____ Patient (Print Name)	_____ Patient's Signature	_____ Date
_____ Patient's Parent (Print Name)	_____ Patient's Parent Signature	_____ Date
_____ Doctor (Print Name)	_____ Doctor's Signature	_____ Date

Authorization for Dental Treatment

I hereby authorize Dr. _____and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

ACKNOWLEDGMENT OF DISCLOSURE AND ACCEPTANCE OF MEMBER FINANCIAL RESPONSIBILITY

_____
Name of Member (the "Member") – *please print clearly*

_____
Treating Provider (the "Provider") – *please print clearly*

The Member or the Member's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the Member's health benefit program.

Accordingly, the undersigned agrees that the Member or Member's legal representative, and not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services.

Code	DOS (If applicable)	Tooth/Surface/Arch	Cost

Date: _____

_____
Signature of Member or Member's Legal Representative

Witness: _____

LIVE BETTER HEALTH CENTER, LLC.

FINANCIAL POLICY:
Our office DOES NOT EXTEND CREDIT. We do not "bill" the patient. We do, however, offer several options for methods of payments so you can choose the one which best suits your personal situation.

A. METHOD OF PAYMENT:
1. Credit Cards: Visa, MasterCard, Discover
2. Cash
3. Care Credit (Payment Plan)

B. DENTAL INSURANCE: (Our office cannot be held responsible for our estimate of your benefits)
Your estimated Co-Payment is due when treatment is rendered.
IF FOR ANY REASON YOUR INSURANCE COMPANY HAS NOT PAID WITHIN 30 DAYS, THE ENTIRE BALANCE BECOMES DUE AND PAYABLE BY YOU.

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize payment to be made directly to LBHC for benefits, which may be due and payable under Insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. Our office is not contracted directly with any insurance plan. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to the above named doctors.

NOTICE OF HIPPA PRIVACY FORMS:
I have read the office's notice of privacy practices.

MISSED APPOINTMENT:
I agree unless my scheduled appointment is cancelled at least 24 hours in advance, that I am liable to pay the broken appointment fee. Please help us serve you better by keeping scheduled appointments.

X-RAY EXAMINATION (FOR FEMALES ONLY):
I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge, I am not pregnant at the time. I agree to diagnostic x-ray examinations as requested by the doctors.

PHOTOGRAPHS AND FILMS:
I further agree to the taking of photographs, films, or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education or the showing to the public at large or other display of such photographs, films or other materials including dental records, x-rays if necessary for dental, scientific and educational purposes.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS EACH DOCUMENT AND ACCEPT THESE TERMS.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Signature of Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In order to provide you with the best quality care, we may need to contact you or an authorized person regarding your treatment and/or appointments. Please list who we may contact aside from you regarding these matters.

Who may we share appointment, treatment and financial information with?

Name: _____ Phone:_____ Relation:_____

Name: _____ Phone:_____ Relation:_____

May we contact you at: Work_____ Cell _____ Home _____

Regarding the Above?

May we leave a detailed message at: Work _____ Cell _____ Home _____

I, _____, understand the Privacy Practices.

I understand that if I wish to read the entire Notice of Privacy Practices a copy will be given to me.

Date: _____

Patient Name:_____

Patient Signature:_____

OSTEONECROSIS OF THE JAW – RISK ACKNOWLEDGEMENT

Patients taking biphosphonate medications may be at an increased risk for developing a serious conditions termed “osteonecrosis of the jaw” (ONJ). While most of the reported cases of ONJ involve patients taking the intravenous (I.V) form of the medication, ONJ has occurred less frequently in patients who are taking the oral form of bisphosphonate medications. These medicines are usually prescribed by the physician for prevention and treatment of osteoporosis.

EXAMPLES OF BISPHOSPHONATE MEDICATIONS (NOT A COMPLETE LIST)

Brand Name	Generic Name
Actonel	Risedronate
Boniva	Ibandronate
Fosamax	Alendronate
Fosamax Plus D	Alendronate
Skelid	Tiludronate
Didronel	Etidronate
Zometa	Zolendronate

Oseonecrosis of the jaw (ONJ) describes a condition that can develop in the absence of dental treatment, or it can occur during or following dental treatment. ONJ can cause severe, irreversible and often debilitating damage to the jaw. ONJ may result in pain, soft-tissue swelling and infection, loosening of teeth, drainage, and exposed bone. Pain and infection may or may not be present. ONJ may remain asymptomatic (no noticeable symptoms) for weeks or months and may only become evident after the finding of exposed bone in the jaw during routine examination. ONJ can occur spontaneously but is more commonly associated with dental procedures that affect the bone, such as dental extractions. Older age (over 65 years), oral glucocorticoid use for chronic conditions, periodontitis (gum disease), and prolonged use of bisphosphonates have been associated with an increased risk for bisphosphonate-associated osteonecrosis or ONJ. There is no effective treatment or cure for this condition.

As each patient’s dental situation is different, different factors have to be considered for the individual patient when weighing the risks versus the benefits of proceeding with any given dental treatment.. Each patient’s case will be considered individually, and a treatment plan will be suggested taking into account the patient’s need for dental/surgical treatment and the patient’s individual risk for developing the ONJ complication. Alternative dental treatment plans may exist to lessen the risk of ONJ and may include less comprehensive.extensive treatment or no dental treatment at all.

I have read this document and understand that risks for osteonecrosis of the jaw (ONJ) exist for patients who take medications of the biphosphonate class, I have discussed the risks and benefits for the proposed treatment with my dental care provider and have considered alternative dental treatments. I have read the attached American Academy of Periodontology “Statement on Bisphosphonates”. I have also been advised to discuss the risks of ONJ with my physician who prescribed the medicine to obtain his or her advice.

_____ _____

Patient’s or Legal Representative’s Signature Date

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3: with 0 meaning you would never *doze or fall asleep* in a given situation; and 3 meaning that there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this 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 mark a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE: _____

Patient Name: _____ Date: _____

TMJ Patient Questionnaire

Patient Name: _____ Date: _____

Answer all that apply.

YES	NO	
		1) Do you have frequent or regular headaches?
		Upon awakening
		Late afternoon
		2) Are your jaw muscles sore or tender?
		3) Are your joints sore or tender when you eat or chew?
		4) Have you ever received an injury to your jaw or face?

If yes: Describe: _____

_____

_____

		5) Do your joints make any noise such as snapping, clicking, or popping?
		6) Do your joints lock when you are trying to open or close?
		7) Do you have any teeth that are sensitive, sore, aching, or uncomfortable?
		8) Have you ever worn a splint or nightguard?

If yes: How many? _____

		9) Are you taking or have you taken any medication for these symptoms?

If yes: Describe: _____

_____

_____

		10) Have you ever seen a dentist or a TMJ specialist for treatment of any of the above symptoms?

If yes: How many? _____