

NEW PATIENT PROFILE

Today's Date _____

Last Name _____ First Name _____ Date of Birth _____

Age _____ Male _____ Female _____ Marital Status _____ Social Security # _____

Address/City/State/Zip _____

Email Address _____

Home Telephone #(_____) _____ Cell #(_____) _____ Work #(_____) _____

Please contact me at: Home ___ Work ___ Cell ___ Other _____

Employer _____ Occupation _____

In case of emergency, please contact _____

Whom may we thank for referring you to our practice?

Name _____

Primary Insurance:

Insurance Company _____ Group# _____

Employer _____ Subscriber's Name & Birthdate _____

Subscriber's ID # _____ Relationship to you _____

Secondary Insurance:

Insurance Company _____ Group# _____

Employer _____ Subscriber's Name & Birthdate _____

Subscriber's ID # _____ Relationship to you _____

For college students:

Name of College _____ City/State _____ FT/PT? _____

Anticipated date of graduation _____

MEDICAL HISTORY PROFILE

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health issues or medications can impact your oral health. Thank you for answering the following questions:

Physician's Name & Address _____

Date of last exam _____

Are you currently under the care of a physician for any medical condition?

If yes, please state condition: _____

Please list prior hospitalizations and surgeries: _____

Have you ever been told that you need pre-medication for dental treatment? Yes ___ No ___

If yes, state the name of the antibiotic: _____

Are you allergic to any of the following:

Local Anesthetics ___ Acrylic ___ Metal ___ Latex ___

Aspirin ___ Penicillin ___ Codeine ___ Antibiotic ___

Other allergies? Yes ___ No ___

If yes, please list: _____

Have you ever had a negative reaction to local anesthetics (Novocain or Epinephrine)? Yes ___ No ___

If yes, please explain: _____

Are you currently taking, or have you taken in the past 3 years, Bone density strengthening medication

(Bis-phosphonates)? Yes ___ No ___

If yes, please explain: _____

Please list any prescription medication(s) & reason(s) you are taking: _____

Please list any over the counter medication, supplements, or herbals you are taking: _____

Do you smoke? Yes ___ No ___ For how long? _____ How much per day? _____

Do you drink alcohol? Yes ___ No ___ For how long? _____ How much per day? _____

Women:

Are you pregnant? Yes ___ No ___ Are you currently nursing? Yes ___ No ___

Are you taking oral contraceptive (birth control pills)? Yes ___ No ___

If yes, name medication: _____

MEDICAL HISTORY

Please check all of the conditions which you have now and date anything you have had in the past:

- | | | | |
|------------------------------|----------------------------------|-----------------------|----------------------|
| AIDS | Diabetes | Hemophilia | Pregnancy |
| Alcohol Addiction | Diet: (Special/Restricted) | Hepatitis- A, B, C | Due Date: _____ |
| Alzheimer's Disease | Dizziness | Herpes | Radiation Treatment |
| Anemia | Drug Addiction | High Blood Pressure | Respiratory Problems |
| Angina | Emphysema | Hives or Rash | Rheumatic Fever |
| Arthritis | Epilepsy | Hypoglycemia | Rheumatism |
| Artificial Joints | Excessive Bleeding | Irregular heartbeat | Sinus Problems |
| Artificial/Leaky Heart Valve | Excessive Thirst | Jaundice | Sleep Apnea |
| Asthma | Fainting | Kidney Disease | Smoke/Chew Tobacco |
| Blood Disease | Frequent Cough | Latex Sensitivity | Stomach Problems |
| Blood Transfusion | Glaucoma | Leukemia | Stroke |
| Bruise Easily | Growths | Liver Disease | Thyroid Problems |
| Cancer | Hay Fever | Mental Disorders | Tuberculosis |
| Chemotherapy | Headaches | Mitral Valve Prolapse | Tumors |
| Cold Sores/Fever Blisters | HIV Positive | Nervous Disorders | Ulcers |
| Contact Lenses | Head Injuries | Pacemaker | Venereal Disease |
| Convulsions | Heart (Attack, Disease, Surgery) | Psychiatric Care | |
| Cortisone Medication | Heart Murmur | | |

Is there anything else about your medical history that we should know? _____

AESTHETIC PROFILE

Are you happy with the appearance of your smile? Yes___ No___

Would you like your teeth to look whiter? Yes___ No___

Are you concerned about existing dental amalgam (silver) fillings? Yes___ No___

If you could improve your smile, what would you like to see changed? _____

DENTAL PROFILE

What is your chief concern today? _____

Is there anything we need to know about your dental history? _____

Dentist _____

Date of last dental visit? _____

Have you had your teeth cleaned regularly? Yes__ No___ How Often? _____

Have you had a complete dental examination, including x-rays, within the last three years? Yes___ No___

Have you had any previous injuries to the face or jaw? _____

Have you ever been diagnosed with TMJ problems in the past? Yes___ No___

If yes, please explain: _____

How many times do you: Floss/week? _____ Brush/week? _____

Do you scrape your tongue? Yes___ No___ Do you use any mouth rinse? Yes___ No___

Do you avoid brushing any areas of your mouth because of tenderness? Yes___ No___

How many times per day do you consume acidic beverages? (i.e. soft drinks, coffee, iced tea) _____

PLEASE CHECK ANY THAT OF THE FOLLOWING THAT PERTAIN TO YOU:

- | | |
|--|---|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Food Traps | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> TMJ/ Jaw Problems |
| <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Clench/Grind Teeth |
| <input type="checkbox"/> Sensitivity to Hot | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Sensitivity to Biting | <input type="checkbox"/> Sleep Apnea |

HAVE YOU EVER HAD? PLEASE CHECK AND DATE:

- | | |
|--|---|
| <input type="checkbox"/> Periodontal (Gum) Therapy | <input type="checkbox"/> Bite Adjustment |
| <input type="checkbox"/> Orthodontics/Braces | <input type="checkbox"/> Extraction of Wisdom Teeth |

WHAT WOULD PREVENT YOU FROM RECEIVING DENTAL TREATMENT?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Cost | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Lack of Time | <input type="checkbox"/> Lack of Importance |

ARE YOU AT HIGH RISK FOR SLEEP APNEA?

This is the “Stop-Bang” Scoring Model. This will help to determine if you are risk for sleep apnea.

STOP

Do you **SNORE** loudly (loud enough to be heard through closed doors)? Yes _____ No _____

Do you often feel **TIRED**, fatigued, or sleepy during daytime? Yes _____ No _____

Has anyone **OBSERVED** you stop breathing during your sleep? Yes _____ No _____

Do you have, or are you being treated for high blood **PRESSURE**? Yes _____ No _____

BANG

BMI: more than 35kg/m²? Yes _____ No _____

AGE: over 50 years old? Yes _____ No _____

NECK: circumference > 16 inches (40cm)? Yes _____ No _____

GENDER: male? Yes _____ No _____

For every yes, please add one point.

Total Score: _____

Low Risk of OSA: 0-2

Intermediate Risk of OSA: 3-4

High Risk of OSA: 5-8

THE EPWORTH SLEEPINESS SCALE

Date: _____ Name: _____ D.O.B. _____ Age _____

This questionnaire measures your general level of daytime sleepiness. Be sure to review your responses with your healthcare professional. Regardless of the questionnaire results, if you have concerns, you are encouraged to discuss them with your healthcare professional.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following 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

Situation	Chance of Dozing
• Sitting and reading.....	_____
• Watching television.....	_____
• Sitting inactive in a public place (e.g., a 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.....	_____

Total Score: _____

Higher scores are associated with more daytime sleepiness. You should discuss your responses and your score with your healthcare professional. This questionnaire is not intended to make a diagnosis or take the place of talking with your healthcare professional.

Sleep Apnea and Snoring Questionnaire

NAME: _____

DATE: _____

What is your main motivation in seeking our help?

_____ spouse or roommate noise complaints _____ bed partner losing sleep due to your snoring
_____ spouse worry about your breathing _____ your health worry
_____ dry mouth _____ daytime sleepiness
_____ poor sleep Other _____

What is your present weight: _____ Present Height _____ ft. _____ in.

Have you gained weight recently? _____

Approximately how much? _____

Snoring:

How long have you been aware of your snoring? _____

Has it caused problems for friends and/or relatives? Yes No

Have you been told your breathing stops while asleep? Yes No

Do you have difficulty breathing through your nose? Yes No

Do you snore in all positions or only on back _____

Sleep:

• Do you have any difficulty falling asleep at night? Yes No

• Have you had any of the following:

○ Frequent urination _____ How many times? _____

○ Excessive Thirst _____

• Approximately how many times per night do you wake up? _____

• Do you wake up gasping or choking? Yes No

• Do you wake up feeling unrefreshed? Yes No

• Do you kick your legs during sleep? Yes No

• How many hours of sleep per night do you get? _____

• How many hours do you feel you need? _____

Daytime Drowsiness:

Do you wake up feeling unrefreshed? Yes No

• Any effects on daily activity? _____

• Any cognitive impairment? _____

Has there been deterioration in your job performance? Yes No

Do you feel sleepy during the day:

Frequently _____ Occasionally _____ Seldom/Never _____ While driving a car _____

What is your caffeine intake? _____

Additional Information:

Do you often wake up with a headache?	Yes	No
Do you know you have any heart irregularities?	Yes	No
Do you have high blood pressure? Yes No What is your BP? _____		
Do you have any loss of memory?	Yes	No
Do you suffer from depression?	Yes	No
Have you had a lab sleep study?	Yes	No

When? _____ Name of Doctor: _____

What professional advice or treatment have you received about your snoring or sleep apnea?

Daily Physical Activities:

Informed Consent for the Treatment of Sleep Disordered Breathing

You have been diagnosed by your physician as requiring treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels, which in turn, may result in the following: excessive daytime sleepiness, irregular heartbeats, high blood pressure, heart attack or stroke.

What Is Oral Appliance Therapy?

Oral appliance therapy for snoring/obstructive sleep apnea attempts to assist breathing during sleep by keeping the tongue and jaw in a forward position during sleeping hours. Oral appliance therapy has effectively treated many patients. Patients with mild or moderate Sleep Apnea are better candidates for improvement with this therapy than patients with severe diagnosis. However, there are no guarantees that it will be effective for you, since everyone is different and there are many factors influencing the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience the symptoms related to your sleep disordered breathing.

Individuals who have been diagnosed as having Sleep Apnea may notice that after sleeping with an oral appliance they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping oxygen level sufficiently high is via a post-adjustment polysomnogram (sleep study) to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term effects of oral appliance use may include excessive salivation, difficulty swallowing (with appliance in place), ear pain, sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term bite changes (how the upper and lower teeth come together). There are also reports of dislodgement of ill-fitting dental restorations and in some cases, it is possible that porcelain may fracture of crown and bridge restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance. Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow up visits with the provider of your oral appliance are mandatory to ensure proper fit and allow an examination of your mouth to assure a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended you cease using the appliance until you are evaluated further. It is advised that the oral appliance be checked at least twice a year to ensure proper fit and that your mouth be examined to assure a healthy condition.

Alternative Treatment for Sleep Disordered Breathing

Other accepted treatments for sleep-disordered breathing include behavioral modifications, positive airway pressure and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider’s office. Failure to treat sleep disordered breathing may increase the likelihood of significant medical complications.

If you have any comfort issues/concerns with your appliance CALL OUR OFFICE RIGHT AWAY! DO NOT WAIT! It is your responsibility to inform us of your concerns. There are options that we can provide to help you. If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below. You will receive a copy of this disclaimer.

Print Name: _____

Signature: _____ Date: _____

In case you are unable to sign digitally, please check the box below:

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above information.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

I give permission to Dental Wellness and Health and staff to discuss any medical/ dental related information including appointments and premedication protocol with:

Date: _____ Print Name: _____

Signature: _____

In case you are unable to sign digitally, please check the box below:

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above information.

For Office 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)

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Please initial each paragraph:

I understand and authorize Dr. Leila Chahine, herein after referred to as Dental Wellness & Health, PC to take all diagnostic materials necessary for diagnostic purposes. This may include radiographs, diagnostic models, and photographs. I understand that the dental treatment agreed upon is my financial responsibility.

I hereby acknowledge that I was given the opportunity to review the Notice of Privacy Act (HIPPA).

I give permission to Dr. Chahine & staff to discuss any medical & dental health related information including appointments and premedication protocol with: _____.

Dental Wellness & Health, P.C. may discuss payment issues with family members or other personal representatives, including the subscriber of the insurance plan, unless I request special privacy protections.

Dental Wellness & Health, P.C. may share my dental information with other professionals if consultation is deemed beneficial.

The information provided above is accurate to the best of my knowledge:

Signature _____

PrintName _____

Date _____

In case you are unable to sign digitally, please check the box below:

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above information.

DOCTOR'S NOTE: _____
