PATIENT REGISTRATION

A B C

Today's Date _____

Patient Number _____

Patient's Name | Sex: M F | Birthdate | Age

Home Address | City | State | Zip

Please Circle One: Single Married Separated Widow | Your Soc. Sec. #

Home Ph.# | Cell Ph. # | E-mail Address

Your Employer | Work Ph. # | How Long Employed

Are you a full time student? ■ Yes ■ No If patient is minor we need: | Mother's DOB | Father's DOB

Person responsible for account | Driver's License # | Relationship

Name of spouse (parent if minor) | Spouse's (parent's) Soc. Sec. #

Spouse's (parent's) Employer | Work Ph. # | Cell Ph. #

EMERGENCY INFORMATION
Name, address, & telephone of a relative not living with you

Reason for this visit

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have double digit insurance coverage, complete this for the 2nd coverage**
Insured's name	Insured's name
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone # DOB	Phone # DOB
SS#	SS#
Group # Local #	Group # Local #

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ■

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) Date

Patient's Name: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	■	■
Where? UR LR UL LL		
-Headaches, earaches, neck pain	■	■
-Jaw joint pain	■	■
-Teeth or fillings breaking	■	■
-Grinding or clenching teeth	■	■
-Bleeding, swollen or irritated gums	■	■
-Loose, tipped or shifting teeth	■	■
-Bad breath	■	■
Do you have or have you had any of the following?		
-Dentures	■	■
-Partial dentures	■	■
-Braces	■	■
-Periodontal (gum) treatments	■	■

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	■	■
Do you smoke or use chewing tobacco?	■	■
How much?_____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	■	■
-Make it straighter	■	■
-Close spaces	■	■
-Replace black metal fillings with tooth colored restorations	■	■
-Repair chipped teeth	■	■
-Replace missing teeth	■	■
-Replace old crowns that don't match	■	■
-Have a smile makeover	■	■

Please share the following dates:

- Your last cleaning _____ /_____
- Your last oral cancer screening _____ /_____
- Your last complete X-Rays _____ /_____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	■	■	Dizziness	■	■	HIV Positive	■	■	Scarlet Fever	■	■
Allergies (Seasonal)	■	■	Drug Addiction	■	■	HPV (Human Papilloma Virus)	■	■	Seizures	■	■
Anemia	■	■	Emphysema	■	■	Jaundice	■	■	Sinus Problems	■	■
Angina (Chest pain)	■	■	Epilepsy	■	■	Jaw Joint Pain	■	■	Sleep Apnea	■	■
Arthritis	■	■	Excessive Bleeding	■	■	Kidney Disease	■	■	Stomach Problems	■	■
Artificial Heart Valve	■	■	Fainting	■	■	Liver Disease	■	■	Stroke	■	■
Artificial Joints	■	■	Glaucoma	■	■	Low Blood Pressure	■	■	Thyroid Disease	■	■
Asthma	■	■	Heart Conditions	■	■	Mitral Valve Prolapse	■	■	Tuberculosis	■	■
Blood Disease	■	■	Heart Lesions (Congenital)	■	■	Nervousness/Depression	■	■	Ulcers	■	■
Bruise Easily	■	■	Heart Murmur	■	■	Pacemaker	■	■	Venereal Diseases	■	■
Cancer	■	■	Heart Surgery	■	■	Pregnant Currently	■	■	Other _____		
Cervical Cancer	■	■	Hepatitis A	■	■	Radiation (head/neck)	■	■			
Chemotherapy	■	■	Hepatitis B	■	■	Respiratory Problems	■	■			
Cortisone Medication	■	■	Hepatitis C	■	■	Rheumatic Fever	■	■			
Diabetes	■	■	High Blood Pressure	■	■	Rheumatism	■	■			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO	
Aspirin	■	■	Percodan	■	■	Tetracycline	■	■	Valium	■	■	Other _____
Darvon	■	■	Latex	■	■	Codeine	■	■	Penicillin	■	■	
Nitrous Oxide	■	■	Local Anesthetic	■	■	Erythromycin	■	■	Sulfa	■	■	

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	■	■	Zometa	■	■
Aredia	■	■	Boniva	■	■
Fosamax	■	■	Herbal Supplements	■	■
Reclast	■	■			

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician Phone Number

_____

Consent:
The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient Signature (Parent if child) Date Dentist Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

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)

_____

_____

Patient Name (PRINT) _____

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) – CIRCLE ONE RESPONSE FOR EACH QUESTION

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

Total Score: _____

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

			No(0)	Yes(1)
BMI (See Attached Chart):	_____	Is it greater than or equal to 30?	0	1
Neck Circumference	_____	Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15lbs in the past 6 months?			0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question	No(0)	Yes(1)
Do you snore?.....	0	1
You, or your spouse, would consider your snoring louder than a person talking….	0	1
Your snoring occurs almost every night……..	0	1
Your snoring is bothersome to your bed partner……..	0	1
Do you feel that in some way your sleep is not refreshing or restful?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day and have difficulty staying awake?.....	0	1
Do you have trouble remembering things or paying attention during the day?.....	0	1
Do you have high blood pressure?.....	0	1

Total Score: _____

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:

When were you diagnosed? (Approx mo/yr) _____
Were you put on CPAP Therapy for treatment? _____
Are you still using your CPAP every night? _____

Total Score: _____

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

Patient Signature:_____ **Date:** ____/____/_____

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.
_____ ESS Score ≥ 8? _____ Pt. Eval ≥ 2? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1?

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity																			
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches) 5 ft= 60inches, 6ft = 72inches	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.*

TMJ HEALTH QUESTIONNAIRE

NAME _____ Date _____

CHIEF COMPLAINT _____

DATE OF ONSET _____

PAIN SYMPTOMS

Do you get headaches? Y N
Do you get migraine headaches? Y N
Do you frequently have neck aches or stiff neck muscles? Y N
Have you ever had chronic shoulder or back pain? Y N
Do you have trouble sleeping soundly? Y N
Are your jaws tired when you awaken? Y N
Are your teeth sore when you awaken Y N

Are your wisdom teeth extracted? Y N

What medication(s), if any, are you taking?

_____

_____

Do you get headaches in right or left temple areas? Y N
Do you get headaches in the front or back of your head? Y N

Do you clench your teeth during the day? Y N
Do you clench your teeth during the night? Y N
Do you grind your teeth when asleep? Y N

When are your symptoms worse?

_____

Does anything make you feel better?

_____

_____

How often do you take medication for relief of pain?

_____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N
Any whiplash neck injuries? Y N

Have you ever been involved in any serious accidents, such as a car accident? Y N
Details _____

_____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N
Are there any foods you avoid eating? Y N
Do you ever get dizzy? Y N
Do you ever feel faint? Y N
Do you ever feel nauseated (sick)? Y N
Is there a family history of jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint? Y N
Has your jaw ever locked when you were unable to open or close? Y N
Do you have difficulty opening wide or yawning? Y N
Have you ever had pain in either jaw joint? Y N
Does your jaw ache when you open wide? Y N

EAR AND EYE SYMPTOMS

Do you have any pain in your ears? Y N
Do you suffer from any loss of hearing? Y N
Do you have itchiness or stuffiness in either ear? Y N
Do you hear ringing, buzzing or hissing sounds in either ear? Y N

Do you wear glasses or contacts? Y N
Are there times when your eyesight blurs? Y N
Do you get pain in, around or behind either eye? Y N

BREATHING

Do you have allergies? Y N
Do you have sinus problems? Y N
Do you have snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N
Have you been diagnosed with Sleep Apnea? Y N
Have you had a sleep study done at a Sleep Clinic (hospital)? Y N

SIGNATURE _____

CityLine Dental Center
ORAL CANCER SCREENING CONSENT FORM

In our continuing effort to provide the most advanced technology and highest standard of care available to our patients, this practice includes the Identafi Oral Cancer detection system as an integral part of your annual oral exam. Identafi uses various wavelengths of light known as fluorescence and reflectance technology to aid our office in seeing oral abnormalities that are or could become cancer. As always, we will visually screen you for oral cancer, but the Identafi greatly enhances our ability to find signs of cancer and dysplasia earlier than possible with our eyes alone.

One person dies every hour from oral cancer in the US, and the mortality has remained unchanged for more than 40 years. Late detection of oral cancer is the primary contributing factor to this alarming statistic. As with most other cancers, early detection is very important. Although age, tobacco and alcohol use increase the probability of oral cancer, 25% of oral cancer victims have **no lifestyle risk** factors. According to the American Cancer Society, more women in the US will be diagnosed with oral cancer this year than will be diagnosed with cervical cancer. Furthermore, there are as many cases of oral cancer caused by the human papilloma virus (HPV), a sexually transmitted disease, as there are HPV-related case of cervical cancer.

Due to the increased prevalence of HPV, this oral cancer screening is recommended annually for everyone age 18 and over. Conducting an oral cancer screening with Identafi improves our ability to identify and evaluate suspicious areas at their earliest stages. Early detection of pre-cancerous lesions can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Proven screening technologies such as a mammogram, Pap smear and colonoscopy are routinely utilized to detect cancer in its early stages. An oral cancer screening with the Identafi is easy and painless and gives this practice the best chance to find any abnormalities you may have at the earliest possible stage.

Although oral cancer screenings are encouraged by the American Dental Association and an insurance code exists for billing, this enhanced exam with the Identafi may not be covered by your insurance. We will be happy to file an insurance claim on your behalf. The fee for this procedure is $45.00.

YES. I authorize CityLine Dental Center to perform an oral cancer screening using the Identafi. I realize that no screening result can guarantee that oral cancer will never occur. Furthermore, I understand that if areas of suspicion are detected, referrals and diagnostic tests may be needed to confirm or dismiss the presence of oral cancer.

Print name: _____

Signature: _____ Date: _____

NO. I would prefer not to have the Identafi exam at this time.

Print name: _____

Signature: _____ Date: _____