

# Craig M. Misch, DDS, MDS, PA

Prosthodontics and Oral & Maxillofacial Surgery  
Implant Reconstructive Dentistry

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # (\_\_\_\_) \_\_\_\_\_ Business # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Did you visit our website (www.drMisch.com)? \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Social Security # \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Spouse's Employer's Phone \_\_\_\_\_  
Closest Relative \_\_\_\_\_ Phone \_\_\_\_\_  
If you are completing this form for another person, what is your relationship? \_\_\_\_\_  
Who referred you to our office? Dr's Name \_\_\_\_\_ Patient \_\_\_\_\_ Ad \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Insured's Name \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Dental Insurance Co. \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
\_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Insured's I.D. # \_\_\_\_\_  
Group # \_\_\_\_\_

*Dr. Misch does not participate in any dental insurance plans. If you have dental insurance we can help you fill out the necessary forms and information to assist you with a claim. Any payment from your insurance company will be directed to your mailing address.*

## DENTAL HISTORY

1. What is your chief complaint (reason for treatment)? \_\_\_\_\_  
\_\_\_\_\_
2. Date of your last dental exam \_\_\_\_\_ Dentist's Name \_\_\_\_\_
3. Are you in any discomfort or pain at this time?..... YES NO
4. Are you satisfied with the appearance of your teeth?..... YES NO
5. Are you able to eat and chew foods satisfactorily?..... YES NO
6. Do you have headaches, earaches or neck pain?..... YES NO
7. Have you ever had any problems associated with any previous dental care?..... YES NO

If yes, please explain

\_\_\_\_\_

## DENTAL HISTORY

Do you now have or have you had any of the following? Please indicate yes with an (x)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Teeth sensitive to cold/hot/sweet | <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Use chewing gum        |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Unpleasant taste                  | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> Food impaction                    | <input type="checkbox"/> Periodontal (gum) treatment       | <input type="checkbox"/> Do you fear treatment  |
| <input type="checkbox"/> Clenching or grinding             | <input type="checkbox"/> Orthodontic treatment (braces)    | <input type="checkbox"/> Do you brush daily     |
| <input type="checkbox"/> Burning of tongue/mouth           | <input type="checkbox"/> Endodontic treatment (root canal) | <input type="checkbox"/> Do you floss daily     |
| <input type="checkbox"/> Swelling or lump in mouth         | <input type="checkbox"/> Complications with extraction     | <input type="checkbox"/> Do you use mouthwash   |
| <input type="checkbox"/> Blisters on lips/mouth            | <input type="checkbox"/> Smoke cigarettes, pipe or cigar   | <input type="checkbox"/> Fluoride supplements   |
| <input type="checkbox"/> Clicking/popping of the jaw joint | <input type="checkbox"/> Use chewing tobacco               | <input type="checkbox"/> Denture adhesive       |

## MEDICAL HISTORY

In the following questions circle yes or no. Your answers are for our records only and will be considered confidential. THESE FACTS HAVE DIRECT BEARING ON YOUR DENTAL HEALTH.

1. Are you in good general health?..... YES NO
2. Has there been any change in your health within the past year?..... YES NO
3. Your last physical examination was on (approximate date) \_\_\_\_\_
4. Are you now under the care of a physician?..... YES NO  
If so, what is the condition(s) being treated? \_\_\_\_\_
5. The name, address and phone # of your physician \_\_\_\_\_  
\_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_
6. Have you ever had any serious illness or operation?..... YES NO  
If so, please list illness/operation with date (year) \_\_\_\_\_  
\_\_\_\_\_
7. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO  
If so, what was the problem? \_\_\_\_\_  
\_\_\_\_\_
8. Do you have or have you had any of the following diseases or problems?
 

a. Rheumatic fever or rheumatic heart disease.....	YES	NO
b. Congenital heart lesions, damaged heart valves.....	YES	NO
c. Heart murmur.....	YES	NO
d. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke).....	YES	NO
1) Do you have pain in your chest upon exertion?.....	YES	NO
2) Are you ever short of breath after mild exercise?.....	YES	NO
3) Do your ankles swell?.....	YES	NO
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?.....	YES	NO
5) Do you have a cardiac pacemaker?.....	YES	NO
e. High blood pressure .....	YES	NO
Low blood pressure.....	YES	NO
f. Allergies or hay fever.....	YES	NO
g. Sinus trouble.....	YES	NO
h. Asthma, bronchitis or emphysema.....	YES	NO

8. Do you have or have you had any of the following diseases or problems?

- |  |     |    |
|--|-----|----|
| l. Hives or skin rash.....   | YES | NO |
| j. Fainting spells or seizures.....                                    | YES | NO |
| k. Diabetes.....   | YES | NO |
| 1) Do you have to urinate (pass water) more than six times a day?..... | YES | NO |
| 2) Are you thirsty much of the time?.....                              | YES | NO |
| 3) Does your mouth frequently become dry?.....                         | YES | NO |
| l. Hepatitis, jaundice or liver disease?.....                          | YES | NO |
| m. Arthritis.....  | YES | NO |
| n. Inflammatory rheumatism (painful swollen joints).....               | YES | NO |
| o. Stomach ulcers.....   | YES | NO |
| p. Kidney trouble.....   | YES | NO |
| q. Tuberculosis.....   | YES | NO |
| r. Do you have a persistent cough or cold?.....                        | YES | NO |
| s. Frequent diarrhea or blood in your stools?.....                     | YES | NO |
| t. Immune deficient disease.....                                       | YES | NO |
| u. Venereal disease (syphilis, gonorrhea).....                         | YES | NO |
| v. Psychiatric treatment or emotional disturbance.....                 | YES | NO |
| w. Hyper or hypothyroidism.....  | YES | NO |
| x. Osteoporosis.....   | YES | NO |
| y. Cancer, cyst or malignancy.....                                     | YES | NO |
| z. Glaucoma.....   | YES | NO |
| aa. Herpes, fever blisters, cold sores.....                            | YES | NO |

bb. Other \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 9. Have you had abnormal bleeding associated with extractions, trauma or surgery? | YES | NO |
| a. Do you bruise easily?.....   | YES | NO |
| b. Have you ever required a blood transfusion?.....                               | YES | NO |
| If so, explain the circumstances _____  |     |    |

10. Do you have any blood disorder such as anemia or sickle-cell?..... YES NO

11. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?..... YES NO

12. Are you taking any drug or medicine?..... YES NO  
If so, what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. Are you taking any of the following:

- |   |     |    |
|---|-----|----|
| a. Antibiotics.....   | YES | NO |
| b. Anticoagulants (blood thinners).....                         | YES | NO |
| c. Medicine for high blood pressure.....                        | YES | NO |
| d. Cortisone or steroids.....                                   | YES | NO |
| e. Tranquilizers.....   | YES | NO |
| f. Antihistamines.....  | YES | NO |
| g. Aspirin (Ecotrin).....                                       | YES | NO |
| h. Insulin or diabetes drug .....                               | YES | NO |
| i. Digitalis or drugs for heart trouble.....                    | YES | NO |
| j. Nitroglycerin.....   | YES | NO |
| k. Oral contraceptive or other hormonal therapy (estrogen)..... | YES | NO |
| l. Vitamins or other nutritional supplements.....               | YES | NO |

14. Are you allergic or have you reacted adversely to:
- |  |     |    |
|--|-----|----|
| a. Local anesthetics (lidocaine, novocaine).....   | YES | NO |
| b. Penicillin or other antibiotics.....            | YES | NO |
| c. Sulfa drugs.....                                | YES | NO |
| d. Barbiturates, sedatives, or sleeping pills..... | YES | NO |
| e. Aspirin or ibuprofen.....                       | YES | NO |
| f. Iodine.....                                     | YES | NO |
| g. Codeine or other narcotics.....                 | YES | NO |
| h. Latex .....                                     | YES | NO |
| i. Adhesive tape (skin reaction).....              | YES | NO |
| l. Other.....                                      |     |    |
15. Have you or a family member ever had an unusual reaction from being put to sleep for surgery?..... YES NO
16. Have you ever required unusually large amounts of local anesthetic for medical or dental treatment?..... YES NO
17. Do you have any disease, condition or problem not listed above that you think the doctor should know about?..... YES NO  
If so, please explain.....
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?..... YES NO
19. Are you wearing contact lenses?..... YES NO
20. Do you drink alcohol?..... YES NO  
If so, how much and how often.....
21. Do you smoke or use tobacco?..... YES NO  
If so, how much and how often?.....
22. Do you use recreational/street drugs?..... YES NO

**WOMEN**

- |  |     |    |
|--|-----|----|
| 23. Are you pregnant?.....   | YES | NO |
| 24. Do you have any problems associated with your menstrual period?..... | YES | NO |
| 25. Are you nursing?.....  | YES | NO |

**RESPONSIBILITY AND CONSENT FOR TREATMENT**

I hereby authorize and request the performance of dental services for myself or for whom I am acting as legal guardian. I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named patient, regardless of insurance coverage.

To the best of my knowledge the information provided on this form is accurate and truthful.

If you had difficulty reading or understanding any of the questions, please make this known to the dentist.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date



# Consent for Disclosure of Health Care Information

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous name: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Practice name: \_\_\_\_\_

My personal health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his/her staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

- 1) Signing and dating a form that my doctor or his/her staff can give me called "Revocation of Consent for Use and Disclosure of Health Information"; or
- 2) Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.

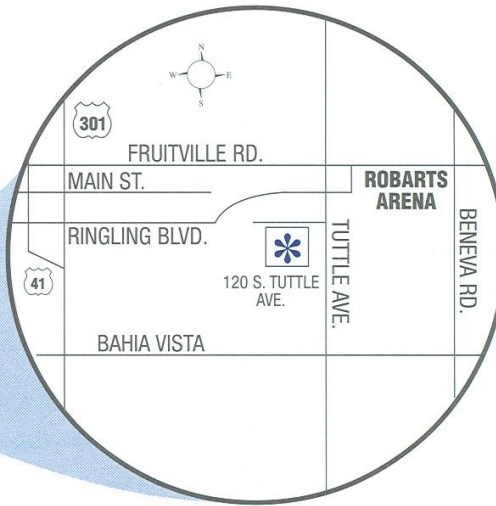
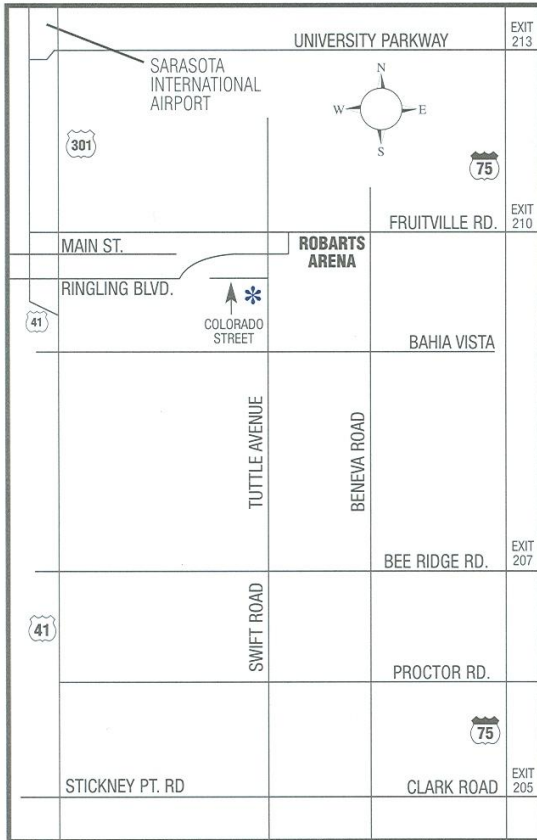
My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice." If I ask, my doctor or his/her staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

\_\_\_\_\_  
Patient (or legally authorized individual) signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient  
(parent, legal guardian, etc.)



**DIRECTIONS**

We are located on the southwest corner of Tuttle Avenue and Colorado Street, near Ringling Boulevard.

**FROM I-75**

Take Interstate 75 to Exit 210 Sarasota/Fruitville Road. Go West on Fruitville Road approximately 3 miles then turn left onto Tuttle Avenue. We are located at the southwest corner of Tuttle Avenue and Colorado Street, just past Ringling Boulevard.

**FROM U.S. 41**

Take U.S. 41 to Fruitville Road/Sarasota and go East approximately 2 miles then turn Right onto Tuttle Avenue. We are located at the southwest corner of Tuttle Avenue and Colorado Street, just past Ringling Boulevard.

**Aches & Claims** / By Robert J. Davis

## **Choosing Dental Implants**

*IF YOU'RE LOSING TEETH and don't want dentures, dental implants may give you a reason to smile. Advances in technology are allowing more people to benefit from the procedure, and more dentists are performing it. But getting a good result can require lots of time, patience and money. Choosing the right surgeon is crucial.*

\* \* \*

Implants involve several steps. First, a titanium screw, which serves as an anchor, is surgically placed into the jawbone. During the same procedure, the surgeon may also insert a post, attached to the anchor that will eventually hold the false tooth or teeth; Often the post is attached in a later procedure. Either way, before the teeth can be added, the anchor has to be in place for several months to allow bone to grow around it and hold it securely. From start to finish, the process can take three months to a year.

Unlike dentures, which lead to bone loss, implants help maintain bone. Also, they don't contribute to the decay and loss of surrounding teeth, as bridges often do. Implants can last 20 years or longer, and people can usually eat whatever they want. The cost of an implant to replace a single tooth is about \$3,500, compared with about \$2,500 for a bridge. For a full set of teeth, the price for implants starts at \$30,000-about 10 times that for a full set of dentures. Typically, insurance doesn't cover implants, but it often pays for bridges and dentures.

Implants tend to be most success-



Tim Foley

ful in the lower front jaw. They are less likely to work in people with thinning bone in the jaw. In such cases, bone may need to be transplanted from other areas, such as the hip.

If done improperly, an implant can cause infection or nerve damage. That's why the professional performing the procedure should be a periodontist or oral surgeon who has special training and extensive experience with implants. Don't automatically assume a dentist is qualified just because he or she is called an "implantologist." Be sure to speak with several other patients who have had implants, and ask the surgeon's office to show you before and after pictures.

To create and fit the false tooth or teeth, it's best to have a separate dentist with expertise in this area. Apply the same scrutiny in choosing this person, and make sure he or she can work well with your surgeon. Don't be afraid to get second or third opinions if you aren't completely comfortable. Remember it's your mouth-and your money.

Actual article from the *Wall Street Journal* on May 27, 2003