



Health History

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. The better we communicate, the better we can care for you.

ABOUT YOU

Today's date: ____ / ____ / ____
MM DD YY

Social Security # ____ - ____ - ____

Name: _____
Last First Middle Initial

I like to be called: _____

Home Address: _____

Apt / Condo# City State Zip

Birthdate: ____ / ____ / ____
MM DD YY

Single Married Divorced Widowed

Special interests, sports, or hobbies: _____

Referred by: _____

Occupation: _____

Your Employer: _____

Address: _____

City State Zip

DENTAL INSURANCE

Do you have dental insurance through your employer? Yes No

If yes, please provide the following information:

Dental Insurance Co. #1: _____

Group # _____

Insurance Co. Phone # (____) _____

Employer's Name: _____

Do you have other Dental Coverage? Yes No

This coverage is through: Spouse Parent Other

Their Name: _____

Their Employer: _____

Their Social Security # ____ - ____ - ____

Their Birthdate: ____ / ____ / ____
MM DD YY

Dental Insurance Co. #2: _____

Insurance Co. Phone # (____) _____

Group # _____

CONTACT

Cell # (____) _____

Home Phone # (____) _____

Work Phone # (____) _____ Ext # _____

Email: _____

When is the best time to reach you? _____

Where? _____ Specific days? _____

In the event of an emergency, is there someone who lives near you that we could contact?

Name: _____ Relationship: _____ Phone # _____

MEDICAL HISTORY

Do you have a personal physician? Y N

Physician Name: _____

Physician Phone # (____) _____

Approximate date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of any physician? Y N

If yes, please explain: _____

Do you smoke or use tobacco in any other form? Y N

Are you presently taking any drugs prescribed by a physician or dentist? Y N

If yes, please list: _____

Have you ever been diagnosed with Sleep Apnea? Y N

If yes, do you wear a CPAP? Y N

Other treatment? _____

For Women: Are you pregnant? Y N Week # _____

Do you need to be premedicated before dental treatment?
 Yes No

Have you had any serious medical problems in the last 5 years? Y N

If yes, please explain: _____

Please circle any of the following that apply

Anemia	Hemophilia / Abnormal Bleeding
Cancer / Chemotherapy	High / Low Blood Pressure
Chronic Hepatitis	HIV+ / AIDS
Diabetes	Kidney Problems
Drug / Alcohol Abuse	Psychiatric Problems
Epilepsy / Seizures / Fainting Spells	Severe Headaches
Fever Blisters / Herpes	Shingles
Heart Attack / Stroke	Sickle Cell Disease / Traits
Heart Murmur / Rheumatic Fever	Sinus Problems
Heart Surgery / Pacemaker	Tuberculosis

Any other serious medical issues not listed above? _____

OFFICE USE ONLY Doctor's comments: _____

Are you allergic to any of the following drugs?

Y N Aspirin	Y N Erythromcin
Y N Codeine	Y N Penicillin
Y N Dental Anesthetics	Y N Tetracycline

Please list any other drugs you are allergic to: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Do you experience stress or anxiety when you visit a dental office? Y N

The approximate date of your last dental visit: _____

Have you ever experienced TMJ problems? Yes No
 (TMJ is pain or discomfort in your jaw joints)

Do you grind your teeth? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Would you like to prevent dentures? Y N

Payment is due in full at the time of treatment unless prior arrangements have been made

I understand that the information that I have given today is correct to the best of my knowledge.

I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

 Signature Date

Our office is HIPPA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Remember...

STOP SMILING AND THE COMMUNICATION ENDS!

Payment & Cancellation Policy

It is the policy of this office that full payment is made for your care at the time of each visit. You may pay by cash, check, credit card, or make arrangements through one of our outside billing services. A late charge of \$25.00 and a service charge of 1.5% per month (18% per annum) on any unpaid balance will be charged on all accounts that exceed 30 days, unless previously written financial arrangements are satisfied. Whenever treatment is necessary, we will create a written financial arrangement.

As a courtesy to our guests with dental insurance, we will complete and submit our insurance claims for you. However, we do not accept assignment of benefits for dental insurance.

How will you be paying for your dental care?

- Cash _____
- Check _____
- Major Credit Card _____ Exp. _____
- Outside Billing Service (credit application required) _____

When you make an appointment we reserve that time solely for you. Please make every effort possible to keep your appointments. An office visit fee up to the amount of the scheduled procedure(s) will be charged for all appointments not kept unless you cancel or reschedule at least 48 hours in advance.

I understand and agree to this Payment and cancellation Policy.
I authorize Barbara Mallonee, DDS, Inc. to keep my signature on file and to charge the above credit card for treatment rendered.

Name

Signature

Date



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

Please circle 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 15 lbs. in the past 6 months? _____	0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle yes or no response for each question No (0) Yes (1)

Do you snore?	0	1
You, or your partner, would consider you snoring louder than a person talking	0	1
Your snoring occurs almost every night	0	1
Your snoring is bothersome to you 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

Have you previously been diagnosed with sleep apnea? _____

If Yes:

 When were you diagnosed? (Approximate MO/YR) _____

 Were you put on CPAP therapy for treatment? _____

 Are you still using your CPAP every night? _____

Total Score: _____

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

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?



Symptoms Screening Form

Name _____ Age _____ Sex _____ Date _____

Please circle any of the following symptoms you may have:

HEAD/FACE

1. Forehead
2. Temporal
3. Tension headaches
4. Migraine headaches
5. Sinus headaches
6. Back of head headaches
7. Hair scalp tender to touch

EAR

1. Ear pain without infection
2. Decreased hearing
3. Clogged, itchy or stuffy
4. Ringing, buzzing
5. Dizziness
6. Balance problems

THROAT

1. Swelling difficulties
2. Feeling of foreign object in throat
3. Sore throat without infection
4. Voice changes
5. Laryngitis
6. Frequent coughing or clearing

JAW

1. Jaw pain
2. Jaw joint pain
3. Clicking/popping jaw joint
4. Grating sound in jaw joint
5. Pain in cheek muscles
6. Uncontrollable jaw movements
7. Jaw locks open/shut
8. Deviates to one side on opening or closing

NASAL

1. Sinus pain
2. Sinus problems
3. Post nasal drainage
4. Allergies

EYES

1. Pain in/around eyes
2. Bloodshot eyes
3. Sensitive to light
4. Tearing of eyes
5. Blurred vision
6. Pressure behind eye

NECK

1. Lack of mobility
2. Stiffness
3. Neck pain
4. Tired/sore neck muscles
5. Shoulder pain
6. Back pain: middle, lower
7. Arm/finger pain/numbness

MOUTH

1. Abnormal opening
2. Limited opening
3. Bad bite
4. Missing teeth
5. Excessive mouth breathing
6. Clench or grind teeth
7. Mouth discomfort
8. Inability to find "bite"

Acknowledgment of Receipt of Privacy Notice and Dental Material Fact Sheet

This document acknowledges that you have received a copy of or have been given access to:

1. Notice of Privacy Practices
2. Dental Material Fact Sheet (available in our office or at the following web site:
http://www.dbc.ca.gov/formspubs/put_dmfs2004.pdf

This document is not a contract, authorization, or release form. This document will remain in your records.

From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check here if you do NOT wish to be notified of such events.

E-mail address _____

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices and the Dental Material Fact Sheet.

Patient's Signature

Date

If the patient is a minor, a parent or legal guardian must sign.

Parent or Legal Guardian

Date

Relationship to Patient

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvements activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including, identifying, or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in our healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.