Patient Information

Patient Name: ____ Date: ________________
Last, First MI (Preferred Name)

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other______________

Birth Date: __________________________ Social Security #: ___________________________

Phone (Home): _______________ (Work): _______________ Cell: _________________Text? Yes ☐ No ☐

Address: ____
Street City State Zip Code

Email Address: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment and the: ☐ mother ☐ father

Name: ____________________________________ ☐Married ☐Single ☐Child ☐Other___________

Birth Date: __________________________ Social Security #: ___________________________

The following is for: ☐ the person responsible for payment and the: ☐ mother ☐ father

Name: ____________________________________ ☐Married ☐Single ☐Child ☐Other___________

Birth Date: __________________________ Social Security #: ___________________________

Phone (Home): _______________ (Work): _______________ Cell: __________________ Text? Yes ☐ No ☐

Address: ____
Street City State Zip Code

Medical Information

Have you ever had any of the following? Please check those that apply:

☐ Allergies	☐ Dizziness	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Rheumatism
☐ Anemia	☐ Epilepsy	☐ Hepatitis	☐ Nervous Disorders	☐ Sinus Problems
☐ Arthritis	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Pacemaker	☐ Stroke
☐ Artificial Joints	☐ Fainting	☐ High Cholesterol	☐ **Pregnancy**	☐ Tobacco Use
☐ Asthma	☐ Glaucoma	☐ HIV	Due date: ______	☐ Tuberculosis
☐ Blood Disease	☐ Hay Fever	☐ Liver Disease	☐ Radiation Treatment	☐ Tumors
☐ Cancer	☐ Head Injuries	☐ Low Blood Pressure	☐ Respiratory Problems	☐ Ulcers
☐ Diabetes	☐ Heart Disease	☐ Mental Disorder	☐ Rheumatic Fever	

Have you ever had a reaction to any of the following? Please check those that apply:

☐ Sulfa ☐ Penicillin (Antibiotics) ☐ Anesthetics like Novacaine ☐ Aspirin ☐ Codeine ☐ Other: _________________

- Are you now under the care of a physician? Yes ☐ No ☐
  If yes, please explain: ____
  Name of Physician: _____________ Phone: ___________ Name of Pharmacy: _______________ Phone: ___________
- Do you have any health problems that need further clarification? Yes ☐ No ☐
  If yes, please explain: ____
- Are you currently taking medicine regularly? Yes ☐ No ☐
  If yes, what medicines? ____
- Have you ever had surgery? Yes ☐ No ☐
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date: ______________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ____________________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment, Name:_____________________ Relationship______________

Employer Name: ______________________________________ Occupation: _______________________________

Address: ____

Street City State Zip Code Phone

The following is for: ☐ the patient's spouse ☐ the person responsible for payment, Name:_________________ _Relationship__________

Employer Name: ______________________________________ Occupation: _______________________________

Address: ____

Street City State Zip Code Phone

Dental Insurance Information

Primary Insurance _____________________________________ Subscriber ID ______________________________

Name of Primary Insured: ______________________________ DOB: ______________ Group # ________________

Secondary Insurance: __________________________________ Subscriber ID: _____________________________

Name of Secondary Insured: _____________________________ DOB: ______________ Group # _______________

Dental History

Do you have any current dental problems? ☐ Yes ☐No If yes, please explain: _______________________________

☐ Yes ☐ No 1. Is this your first dental visit? If no, date of last complete dental examination. ________________________

☐ Yes ☐ No 2. Are your teeth sensitive?

☐ Yes ☐ No 3. Do your gums bleed or hurt?

☐ Yes ☐ No 4. Have you noticed any loose teeth or change in your bite?

☐ Yes ☐ No 5. Have you noticed any mouth odors or bad tastes?

☐ Yes ☐ No 6. Does food tend to become caught between your teeth?

☐ Yes ☐ No 7. Do you clench or grind your teeth?

☐ Yes ☐ No 8. Have you ever had Orthodontic treatment?

☐ Yes ☐ No 9. Have you ever seen a Periodontist?

☐ Yes ☐ No 10. Has your bite ever been adjusted?

☐ Yes ☐ No 11. Do you have clicking or popping in your jaw?

☐ Yes ☐ No 12.Do you have difficulty opening or closing your mouth?

☐ Yes ☐ No 13. Have you ever been told you have a TMJ problem?

☐ Yes ☐ No 14. Do you get frequent headaches?

☐ Yes ☐ No 15. Would you like to keep your teeth all your life?

☐ Yes ☐ No 16. Have you ever had any complications following dental treatment? If yes, please explain

____

☐ Yes ☐ No 17. Do you feel nervous about having dental treatment? If yes, what is your biggest concern?

____

☐ Yes ☐ No 18. Have you ever had an upsetting dental experience? If yes, please describe

____

☐ Yes ☐ No 19. Are you happy with the appearance of your teeth? If no, what would you like to change?

____

Consent for Services

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication.
4. I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.
5. I hereby give Dr. Pominville the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present future compensation in connection with the use of said photographs/slides.

____ Date: ______________ Relationship to Patient: _______________

Signature of patient, parent or guardian

Screening for Sleep Disordered Breathing
S.T.O.P. / B.A.N.G. Questionnaire

Do you **SNORE**?…………………………………………………………………… YES NO

Are you **TIRED** during the day?……………………………………………….. YES NO

Have you been **OBSERVED** gasping or stop breathing during sleep?…… YES NO

Do you have high blood **PRESSURE**?…………………………………………YES NO

Is your **BMI score 30 or greater**?
(see clipboard for BMI graph)……………………………………………………YES NO

Is your **AGE 50** or more?………………………………………………………YES NO

Neck Circumference
Male 17 inches or greater?
Female 16 inches or greater?…………………………………………...YES NO

Gender = Male?…………………………………………………………………… YES NO

Low Risk YES to 0-2 questions
Medium Risk YES to 3-4 questions
High Risk YES to 5-8 questions

Reflux Symptom Index (RSI) Screening
Koufman Reflux System Index Quiz (RSI)

Within the last MONTH, how did the following problems affect you?	**0 = No** Problem **5 = Severe** Problem					
Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucous or postnasal drip	0	1	2	3	4	5
Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5
Coughing after you ate or after lying down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

A score of 15 or more means that you have a 90% chance of having reflux

Your RSI is ______

Patient Name: ____ Date: ____________________

ADVANCED DENTAL CARE
Dr. Sam Pominville
7626 N. State Street
Lowville, NY 13367
Phone: 315-376-3121

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, acknowledge that I have received a copy of Advanced Dental Care's notice of Privacy Practices. This Notice describes how Advanced Dental Care may use and disclose my protected dental information, certain restrictions on the use and disclosure of my dental information, and rights I may have regarding my protected dental information.

I permit Advanced Dental Care to disclose my protected dental information to any of the following people listed below. I understand that this request will not expire until I revoke it in writing. <u>If this patient is a minor, the following individuals may accompany my child to appointments in my absence</u>. Please check one box below and add your initials.

Name of Individuals	Relationship/Phone Number
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________

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Patient Authorization Update

AUTHORIZATION TO PAY BENEFITS TO DENTIST

I hereby authorize payments directly to the dentist of the dental benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. **Please check one box below and add your initials.**

☐ I authorize __________   ☐ I *do not* authorize __________

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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the dentist to release any information acquired in the course of my treatment necessary to process insurance claims or to third-party contractors upon their request. This may include correspondence between other medical or dental offices. **Please check one box below and add your initials.**

☐ I authorize __________   ☐ I *do not* authorize __________

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AUTHORIZATION TO RECEIVE EMAILS/TEXT MESSAGES AND TO LEAVE DETAILED MESSAGES

Text messaging is not secure and could be viewed by third parties. I hereby authorize the dentist to email/text with me about my health, appointments and treatment. I also hereby authorize the dentist to leave detailed messages, including Voicemail, In-Person, or Other Authorized Forms of Communication about my health, appointments and treatment. **Please check one box below and add your initials.**

☐ I authorize __________   ☐ I *do not* authorize __________

______________________________ ______________________________ ______________

SIGNATURE (Patient or Parent/Guardian if Minor)   RELATIONSHIP TO PATIENT   DATE