

Patient _____
 Social Security # _____
 Birthdate _____ Age _____
 Address _____
 City/State/Zip _____
 Phone _____

Date _____ Chart# _____
 E-mail Address _____
 Occupation _____
 Employer (or School) _____
 Address _____
 Dental Ins.Co. _____
 Group# _____

HOME WORK/CELL
 Has any other member of your family been treated in our office? YES NO

Who may we thank for referring you? _____

Person responsible for account: PATIENT SPOUSE
 PARENT of child OTHER

PARENT of child

SPOUSE

| | | |
|-------|-----------------|-------|
| _____ | Name | _____ |
| _____ | Birthdate/S.S.# | _____ |
| _____ | Employer | _____ |
| _____ | Address | _____ |
| _____ | Dental Ins.Co. | _____ |
| _____ | Group# | _____ |
| _____ | Work Phone | _____ |

It is very important that we know about your medical and dental history. Many things have a direct bearing on your dental health and treatment. We will review the questionnaire and discuss it with you in private. Information you give us is strictly confidential and will not be released to anyone without your permission.

Medical Doctor _____

Date of last medical exam _____

Have you ever had (please check either yes or no)

any surgery or been hospitalized within the past two years?

- YES NO
- heart trouble
 - rheumatic fever or heart murmur
 - heart valve replacement or repair
 - high blood pressure or stroke
 - bleeding problems, hemophilia
 - osteoporosis, osteopenia, arthritis
 - diabetes or hypoglycemia
 - thyroid disorder
 - asthma or lung disease, tuberculosis
 - kidney disease
 - epilepsy or seizure disorder
 - neurologic or psychiatric problem
 - ulcer or stomach/GI problem
 - hepatitis or other liver disease
 - venereal disease (herpes, syphilis, gonorrhea)
 - AIDS or HIV positive blood test
 - Drug or alcohol dependency
 - Do you smoke or use chewing tobacco?

Are you allergic to anything or have you ever had an adverse reaction to any medication?

Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma?

Have you ever had a serious problem associated with previous dental treatment?

Please list all drugs you are taking, including any herbal or vitamin supplements, over-the-counter or prescription medications, or street drugs.

Women Only

- Are you pregnant or nursing?
- Do you use birth control pills?
 (Antibiotics can interfere with birth control pills.)

Please continue on back

Our Commitment to You

Successful relationships are built on trust and communication. We believe that our patients expect and desire quality dentistry. We will make every effort to work with you and to listen to what you have to say in order to determine your needs. We strive to deliver exceptional service. There are no shortcuts to quality.

Consent for Treatment

I hereby authorize the doctor or staff to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of me or my dependent's dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment agreed upon by me and to give such assistance as required to provide proper care. I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents carries certain risks. I understand that I may ask for a full explanation of any possible complications.

I understand that I am responsible for payment of all services rendered on behalf of me or my dependents, regardless of insurance benefits. I understand that payment is due at the time service is rendered unless other arrangements have been made. I am aware that this office charges for broken appointments without adequate notice. I understand that a 1.5% (18% APR) charge will be assessed to my account for any balance over 45 days old. Accounts more than 90 days past due may be turned over to a collection agency in which case a collection fee will be assessed. I certify that the information I have given on this form is correct to the best of my knowledge.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR)

Photography Release

I authorize the taking of photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television) and professional publications (dental magazines and journals.) I further understand that if the photographs, slides, and/or videos are used in a publication or as part of a demonstration, my name or other identifying information will be kept confidential and I will not receive compensation, financial or otherwise, for the use of these photographs.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR)

Insurance Release: I hereby authorize release of any information necessary to process and/or pay my insurance claims.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR)

DATE

Acknowledgment of Receipt of Notice of Privacy Practices (HIPPA)

I have received a copy of the Notice of Privacy Practices of this office. (You have the right to refuse to sign this acknowledgment.)

NAME (Please Print)

SIGNATURE OF PATIENT (or GUARDIAN OF MINOR)

DATE

~~~~~Office Use Only~~~~~

We were unable to obtain acknowledgment of receipt of our Privacy Practices Notification from the person noted above for the following reason.

- | | |
|---|---|
| <input type="checkbox"/> An emergency prevented us from obtaining acknowledgment | <input type="checkbox"/> The individual was unwilling to sign |
| <input type="checkbox"/> A communication barrier prevented us from obtaining acknowledgment | <input type="checkbox"/> Other: |



Epworth Sleep Test

How likely are you to doze off or fall asleep in the following situations:

Use the following scale:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (ie. A theater) _____

Lying down to rest in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car while stopping for a few minutes in Traffic _____

Add up total to give Your Score _____

Height _____ Age _____ Neck size _____

Weight _____ M/F _____ BMI _____

Do you snore or has someone told you that you snore Y___ N___

Do you wear a retainer or Bruxism appliance Y___ N___

Do you have a CPAP machine Y___ N___

If you answered yes to above how often do you use it? _____

Gary S Kodish DDS

Jodi Kodish-Stav DDS

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