MIRAMAR BEACH DENTAL & ORTHODONTICS

Welcome! Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help. (Please print)

Todays Date_____

Name _____[ ]Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____

Address _____ Occupation _____[ ] Male [ ] Female
City _____State_____Zip _____ Hm#(___)_____

Employer _____ Wk# (___)_____Ext_____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell# (___)_____

DOB ___/___/_____ SSN# ____-___-_____ E-mail _____@ _____.____

Spouses Name _____ Cell# (____)_____

Spouses Occupation _____Wk# (____)_____

Is patient a full time student? [ ] No [ ] Yes – If yes, Name of School _____

Responsible Party (if different than patient)

Name _____
Address _____
City _____State_____Zip _____
Hm#_____
Wk#_____
DOB ___/___/_____ SSN# ____-___ ____
E-mail_____@ _____.____
Relationship _____

YOUR PREFERENCES:
Do you prefer your appointment reminders by:
[ ] E-mail [ ] Phone [ ] Text
Do you prefer to receive call from our office at:
[ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you?
_____
How do you wish to be addressed by our staff?
_____

Dental Insurance

Subscribers Name _____Relationship to patient _____
Subscribers Employer _____
Subscribers DOB ___/___/_____ Subscribers SSN# ____-___ ____
Insurance Company_____Policy #_____Group # _____
Insurance Company Telephone# _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE: [ ] YES [ ] NO IF YES – PLEASE COMPLETE THE FOLLOWING

Secondary Dental Insurance

Subscribers Name _____Relationship to patient _____
Subscribers Employer _____
Subscribers DOB ___/___/_____ Subscribers SSN# ____-___ ____
Insurance Company_____Policy #_____Group # _____
Insurance Company Telephone# _____

CONFIDENTIAL

MIRAMAR BEACH DENTAL & ORTHODONTICS

MEDICAL HISTORY and CONSENT

PLEASE MARK YES OR NO TO ALL

Patient Name: Date:

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y	N
Anaphylaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____

_____

_____

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Disease	Y	N
Chest Pain/Angina	Y	N
Congestive Heart	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid Problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Ears Ringing	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney Disease	Y	N
Nocturia	Y	N

General

Current Weight: _____lbs

Height: _____ft _____ins.

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip replacement	Y	N
Liver Problems	Y	N
Recent trauma/Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N
PregnancY	Y	N

Hematological

Bleeding Problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw Problems (TMD)	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Swallowing	Y	N
Difficulty chewing	Y	N
Orthodontics	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Teeth Grinding	Y	N
Tooth Pain	Y	N
Wisdom teeth extract	Y	N

Do you wear removable teeth? Y N

Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N
Osteoporosis	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness/Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis(MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorders	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea (shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N

How often? _____

Has anyone told you that you snore? Y N

Social History

Do you smoke? Y N

Packs per day _____

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages? Y N

_____Drinks per day/week/month

Do you use recreational drugs? Y N

Thank you for your time in completing these forms. This information will assist our staff in providing optimal care.

MIRAMAR BEACH DENTAL & ORTHODONTICS

MEDICAL HISTORY and CONSENT

PLEASE MARK YES OR NO TO ALL

Patient Name: Date:

List any medications that you are taking:

Medication	Dosage	Reason

List any surgeries or hospitalizations you have had:

Date	Surgery	Reason

Are you currently taking Bisphosphonates or other medication for osteoporosis? Y N

List and detail any medical condition or history not listed above:

Are you currently under the care of a physician? Y N If yes, please list:

Primary Physician's Name: Physician's Phone:

Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Jason E Baker, DDS and his associates to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Jason E Baker, DDS and his associates to perform any and all forms of treatment deemed necessary. I understand that the use of local anesthetic agents embodies certain risk and consent to their use as deemed appropriate. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status. I understand that if refusing treatment, radiographs or evaluations could lead to a departure in the standard of care, Jason E Baker, DDS may dismiss me from the practice. Initial:_____

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent (s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Jason E Baker, DDS and his associates and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s). Initial:_____

PATIENT AGREEMENT: I agree to treat staff with respect, verbally and physically. I understand that abusive or discourteous behavior will not be tolerated. I understand that this practice may discharge me as a patient if assault, battery, or verbally abusive behavior from me, a family member, or legal guardian threatens the safety of an associate, other patient and/or healthcare provider. Initial:_____

PHONE/MOBILE DEVICE AGREEMENT: I agree to silence my phone or mobile device, and refrain from using my phone or mobile device in the operatory during my appointment time. Initial:_____

Consent (adult): **Date:** _____

Name of Patient: _____ **Signature:** _____

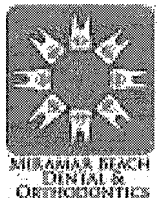
Consent (for minor child): **Date:** _____

Name of Parent/Guardian: _____ **Signature:** _____

Notice of Privacy Practices – Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging that our notice of our practices' policies and your rights regarding PHI have been made available to you. I allow release of pertinent medical records to my insurance company (if any).

Signature of Patient/Guardian: Date:

Doctor Signature: Date:



Cancellation and Broken Appointment Policy

Patient Name:_____ **Date:** _____

When you schedule an appointment with us, we promise to set aside enough time to provide you with the highest quality care on a date and time you agree to.

In return, we ask the following:

- I agree to be on time for my appointments. If I arrive more than 15 minutes late for my appointment, it may be necessary to cancel/reschedule it. Initial:_____
- If I need to cancel or reschedule and appointment, I will contact your office as soon as possible, but not less than 48 hrs prior to my scheduled appointment. This gives adequate time to schedule another patient who is waiting for an appointment. Initial:_____

DEFINITION OF A "BROKEN APPOINTMENT":

A broken appointment is when you:

- Cancel or reschedule an appointment with less than 48 business hours' notice.
- Do not show up for the scheduled appointment.

POLICY AND FEES:

- Cancellation or rescheduling of an appointment less than 48 business hours will be considered a broken appointment. We understand that illness, emergencies, flat tires, and bad weather do occur, consideration will be taken for emergencies and a charge will be made or not made at our discretion.
- Broken appointments will be charged a fee:
  $75 for a hygiene appointment
  $150 per hour for a doctor's appointment

I understand that this practice may discharge me as a patient if:

–I miss multiple scheduled appointments without notifying the office or I notify them less than 24 hrs in advance.
–If multiple appointment have to be cancelled/rescheduled due to late arrival (15 minutes or longer)

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only.
When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

I have read and understand the above mentioned policy.

Patient signature (Parent or Guardian if minor) Date

MIRAMAR BEACH
DENTAL &
ORTHODONTICS

Patient's Private Health Information

Patient Name: _____ Date of Birth: _____

Before we can discuss your medical or dental information/condition with anyone (spouse, children, significant other, etc.) we must have the following authorization on file. This list can be modified by the patient, parent, or legal guardian only when a written request is received to do so.

The attending dentist/hygienist and his/her staff have my permission to discuss and/or release my protected health information with/to the following list of individuals. IF YOU DO NOT WISH TO LIST ANYONE, PLEASE WRITE "NO ONE".

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

You may list a password for us to release this information. It is your responsibility to give the password to everyone on your list.

PASSWORD: _____

_____

Signature of Patient/Parent/Guardian Date

_____

Signature of Witness Date

SLEEP SCREEN QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____ BMI: _____ Collar size/Neck circumference: _____

	YES	NO
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐
Are you currently being treated for OSA?	☐	☐
Are you aware of a family history of OSA?	☐	☐
Are you aware of clenching or grinding your teeth at night?	☐	☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	Chance of dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. In a car while stopped for a few minutes in traffic	_____

STOP - BANG

			Yes	No
1.	Snore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	☐	☐
2.	Tired	Do you often feel tired, fatigued or sleepy during the daytime?	☐	☐
3.	Obstruction	Has anyone observed you stop breathing during your sleep?	☐	☐
4.	Pressure	Do you have or are you being treated for high blood pressure?	☐	☐
5.	BMI	Is your body mass index greater than 28?	☐	☐
6.	Age	Are you 50 years old or older?	☐	☐
7.	Neck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	☐	☐
8.	Gender	Are you a male?	☐	☐

- ☐ Class 0 – No Bruxism/Clenching
- ☐ Class I - Mild bruxism defined as visual exam showing minor teeth wear or 1-2 bruxism bursts per sleep hour
- ☐ Class II – Moderate bruxism defined as visual exam showing moderate teeth wear or 3-4 bruxism bursts per sleep hour
- ☐ Class III – Severe bruxism defined as visual exam showing teeth wear or 5+ bruxism burst per sleep hour.