WELCOME TO OUR PRACTICE

We would like to welcome you as a new patient. We strongly believe in preventive and restorative care and have been fortunate enough to build a practice of patients who value their oral health.

PATIENT INFORMATION (CONFIDENTIAL)

NAME____ SOC SEC #______________

FIRST MI LAST

ADDRESS___________________________ CITY_____________ STATE_______ ZIP________

BIRTHDATE_________ HOME PHONE_________________ WORK PHONE__________________

CELL PHONE ____________________ E-MAIL ADDRESS ________________________________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER____

SPOUSE/PARENT NAME__________________________________WORK PHONE_____________

WHO MAY WE THANK FOR REFERRING YOU?____

CONTACT IN CASE OF EMERGENCY__________________________PHONE_________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT___________________________________

RELATIONSHIP TO PATIENT____________________ HOME PHONE_______________________

ADDRESS____

EMPLOYER___________________________________ WORK PHONE______________________

BIRTH DATE____________________ SOC SEC #_________________________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED___________________________ RELATIONSHIP TO PATIENT____________

BIRTHDATE________________________________ SOC SEC #__________________________

NAME OF EMPLOYER__________________________________ WORK PHONE______________

INSURANCE CO.____________________________ PHONE________________ GRP #_______

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO

NAME OF INSURED________________________________RELATIONSHIP TO PATIENT_________

BIRTHDATE___________________________ SOC SEC #_______________________________

NAME OF EMPLOYER__________________________________ WORK PHONE______________

INSURANCE CO.____________________________ PHONE________________ GRP #_______

____ ______________

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy

of this office's Notice of Privacy Practices.

I, _______________________________________, DO / DO NOT

give permission for Dr. Reiler and her staff to discuss my treatment

with _____________________________ until further notice.

It is standard courtesy for this office to file all insurance claims on behalf of the patient. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payers and/or health/dental practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. Although your employer carries a contract with the insurance company, this does not constitute as guarantee of payment and Dr. Reiler is not a party to that contract. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

***Cancellation Policy**: We have a policy for cancellations and no show appointments, if verbal notice is not received more than 48 hours before the appointment, you are subject to a cancellation fee of $50.00.*

Red Flag Rule: The Red Flag Rule was created by the Federal Trade Commission, along with other government agencies such as the National Credit Union Administration, to help prevent identity theft. The rule was passed in January 2008. In order to comply with this rule, our office will be requiring the following information in order to be treated in our office.

1. All new patients will be required to present a valid photo identification card issued by a local, state or federal government agency, and we shall copy said identification to keep in our files:
   a. In case where the new patient is a minor, photo identification of the patient's responsible party will be obtained; and
   b. In the case where a new patient does not have a valid photo ID, two forms of non-photo identification, one of which is issued by a state or federal agency, will be obtained as well as a water or utility bill or other form identifying the correct or current address.

X____

SIGNATURE OF PATIENT OR GUARDIAN

MEDICAL HISTORY FORM

	YES	NO
Are you in good health	☐	☐
Have there been any changes in your general health within the past year	☐	☐
Date of your last physical exam:________________________		
Physician's Name ___________________________		
Address________________________________		
Phone No.______________________________		
Are you now under the care of a physician	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness	☐	☐
Please explain:_____________________________		
Are you taking any medications, including non-prescription or over the counter drugs?	☐	☐

If yes, what medicine(s) are you taking ____________________

	YES	NO
Have you had any abnormal bleeding	☐	☐
Do you bruise easily	☐	☐
Have you had a blood transfusion	☐	☐
Have you had recent weight loss	☐	☐
Have you ever taken fen-phen or redux	☐	☐
Do you use tobacco	☐	☐
Do you or have you used controlled substances	☐	☐
Are you wearing contact lenses	☐	☐
Do you have any disease, condition or problem you think I should know about	☐	☐
Have you ever taken Bisphosphonate	☐	☐

COMMENTS_______________________________

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
Local anesthetics like novocaine	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Iodine	☐	☐
Any metals (e.g., nickel, mercury, etc.)	☐	☐
Latex/Rubber	☐	☐
Other (please list) ___________________________		

WOMEN ONLY:	YES	NO
Are you pregnant or think you may be pregnant	☐	☐
Are you nursing	☐	☐
Are you taking birth control pills	☐	☐
Aspirin	☐	☐

COMMENTS_______________________________

DO YOU OR HAVE YOU EVER HAD THE FOLLOWING:

	Y	N
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Heart Defect or Heart Murmur	☐	☐
Heart Trouble, Heart Attack	☐	☐
Angina	☐	☐
Chest Pain	☐	☐
Pacemaker	☐	☐
Heart Surgery	☐	☐
High/Low Blood Pressure	☐	☐
Congenital Heart Problem	☐	☐
Mitral Valve Prolapse	☐	☐
Stroke	☐	☐
Shortness of Breath	☐	☐
Persistent Cough	☐	☐
Swelling of feet, ankles, hands	☐	☐
Lung or breathing Problems	☐	☐
Asthma or Hay Fever	☐	☐
Tuberculosis	☐	☐

	Y	N
Cough that produces Blood	☐	☐
Allergies	☐	☐
Sinus Trouble	☐	☐
Kidney Trouble	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Radiation	☐	☐
Tumors	☐	☐
Epilepsy or Seizures	☐	☐
Glaucoma	☐	☐
Tonsillitis	☐	☐
Mental Health Care	☐	☐
Nervousness	☐	☐
Chemical Dependency	☐	☐
Cortisone Treatment	☐	☐
Hypoglycemia	☐	☐
Hepatitis, Jaundice	☐	☐
Liver Disease	☐	☐

	Y	N
Stomach Ulcer	☐	☐
Thyroid Problems	☐	☐
Anemia	☐	☐
Hives or Skin Rash	☐	☐
Fainting or Dizzy Spells	☐	☐
Diabetes	☐	☐
Aids or HIV Infection	☐	☐
Sexually Transmitted Disease	☐	☐
Cold Sores/Fever Blisters	☐	☐
Arthritis or Rheumatism	☐	☐
Joint Replacement or Implant	☐	☐
Back Problems	☐	☐
Eating Disorders	☐	☐

COMMENTS_____________

BP____________ Pulse ____________ Weight _________ Height __________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_______________________________________ _______________

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

DOCTOR'S COMMENTS: ____

SIGNATURE______________________________**DATE**______________

DENTAL HISTORY FORM

REASON FOR THIS VISIT ____

WHEN WAS YOUR LAST DENTAL VISIT________________________ REASON________________________

HOW OFTEN DID YOU ROUTINELY VISIT THE DENTIST ____________________________

PREVIOUS DENTIST (NAME & LOCATION) ____________________________

How Often Do You Brush ____________________ Floss _______________ Mouthrinse _________________

	YES	NO
Do your gums bleed while brushing/flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do you feel pain to any of your teeth	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck or jaw injuries	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking, Pain	☐	☐
Difficulty in opening or closing	☐	☐
Have you ever received oral hygiene instructions	☐	☐
Do you snore?	☐	☐
Do you or have you used a CPAP machine	☐	☐

	YES	NO
Do you bite your lips or cheeks	☐	☐
Do you have loose teeth	☐	☐
Does food collect between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Ever worn a bite plate or other appliance	☐	☐
Have you had your wisdom teeth extracted	☐	☐
Have you ever had any prolonged bleeding following extractions	☐	☐
Do you wear dentures or partials		
If yes, date of replacement _________________		
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you like the general appearance of your teeth?	☐	☐
Their color?	☐	☐
Spacing?	☐	☐
Straightness?	☐	☐
Size?	☐	☐
Have you ever worn braces?	☐	☐
Are you happy with the freshness of your breath?	☐	☐

	YES	NO
Are you happy with the appearance of your teeth in the back?	☐	☐
Are you happy with your crowns/ bridges/partials/dentures?	☐	☐
Are you happy with other cosmetic dentistry you have had?	☐	☐

If you could change anything about your smile, what would you change? ______________________________

____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ ____________

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

DOCTOR'S COMMENTS: ____

____

____

SIGNATURE_________________________________**DATE**___________

PATIENT'S NAME_________________________________ DATE OF BIRTH ____________

EPWORTH

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to mark the most appropriate box for each situation.

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

Situation	Score 0 - 3
Sitting and reading	_________
Watching TV	_________
Sitting, inactive, in a public place (theater, meeting, etc)	_________
As a passenger in a car for an hour without a break	_________
Lying down to rest in the afternoon when circumstances permit	_________
Sitting and talking to someone	_________
Sitting quietly after lunch without alcohol	_________
In a car, while stopped for a few minutes in traffic	_________
TOTAL SCORE	_________

A score of ten or above indicates you may be having a problem with daytime sleepiness. However, below ten does not necessarily mean you do not have a problem.

Frequency 0-1 times/week 1-2 times/week 3-4 times/week 5-7 times/week

On average in the past month, how often have you snored or been told that you snored?

Never _____ Rarely _____ Sometimes _____ Frequently _____ Almost always _____

Do you wake up choking or gasping?

Never _____ Rarely _____ Sometimes _____ Frequently _____ Almost always _____

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never _____ Rarely _____ Sometimes _____ Frequently _____ Almost always _____

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never _____ Rarely _____ Sometimes _____ Frequently _____ Almost always _____