Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Widowed ☐ Divorced

Birthdate: _____ Social Security #: _____ DL#: _____

Address: _____
Street Apt # City State Zip

E-Mail Address: _____
Appointment reminders: ☐ **Email** ☐ **Text Message** ☐ **Phone Call only**
Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Employer's Name: _____ Occupation: _____

Spouse Name: _____ Birthdate: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Health Information

Date of Last Dental Visit: _____ Reason for Today's Visit: _____

Primary Care Physician: _____ Phone #: _____

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

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints (Replacement)
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ **Pregnancy**
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problem
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Pacemaker
☐ Venereal Disease
☐ **Codeine Allergy**
☐ **Penicillin Allergy**
☐ **Sulfa Allergy**
☐ **LATEX ALLERGY**

Are you taking any medications? Please list:
_____
_____
_____
_____
_____

☐ Ulcers

Which of the following do you experience?

- Frequent, heavy snoring? ☐ Yes ☐ No
- Significant day time sleepiness? ☐ Yes ☐ No
- Have you ever been told you stop breathing while sleeping? ☐ Yes ☐ No

- Do you gasp at times when waking up? ☐ Yes ☐ No
- Do you feel unrefreshed in the morning? ☐ Yes ☐ No
- Do you have morning headaches? ☐ Yes ☐ No
- Are you aware of any teeth grinding or clenching at night? ☐ Yes ☐ No
- Do you smoke or use tobacco? ☐ Yes ☐ No If so, how much? _____

Which of the following do you own?

1. CPAP? ☐ Yes ☐ No If yes, how often do you wear it? _____
   When did you start wearing it? _____
2. Night guard? ☐ Yes ☐ No How often do you wear it? _____
3. Retainer? ☐ Yes ☐ No How often do you wear it? _____

Have you ever been advised to take antibiotics before a dental appointment? ☐ Yes ☐ No
If yes, please explain: _____

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

Have you ever been admitted to a hospital or needed emergency care during the past two years?
☐ Yes ☐ No If yes, please explain: _____

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
Name of physician: _____ Phone #: _____

Do you have any health problems that need further clarification? ☐ 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. I acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Patient, Parent or Guardian Date

Dental Insurance Information

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's address _____
Street City State Zip

Insured's Birthdate: _____ Insured's Social Security #: _____

Insured's Employer: _____

Insured's Plan Name and Address: _____

Insurance Phone #: _____ Group/Plan #: _____

Referral Information

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

☐ Friend ☐ Relative ☐ Internet ☐ Church Bulletin ☐ Another Dental Office ☐ Drive by

☐ School/Work ☐ Other: _____

Responsible Party Information

Name: _____ Relationship to Patient: _____

Address: _____

Street City State Zip

DOB: _____ Social Security #: _____ Email address: _____

Home #: _____ Work #: _____ Ext: _____ Cell/Other #: _____

Employer's Name: _____ Occupation: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid in full at the time services are performed.

In most instances, we will accept assignment of insurance benefits. However, all charges are the responsibility of the patient regardless of insurance. If your insurance company does not make payment within a reasonable period (30 days) you will be asked to pay the unpaid portion. Any insurance payments received by your insurance at that point will be credited to your account and a refund will be issued to you.

Our credit card merchant charges a 3.5% processing fee for all credit and debit card transactions. Payment can also be made by check or cash if you prefer.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be Instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Dr. Peck and his staff are fully compliant with all federal and state privacy laws. No one from this office will discuss your medical/dental condition or treatment with anyone outside of this office without your consent.

I understand that the Health Information Privacy Act (HIPPA) is available for me to read at any time.

_____ _____

Signature of Patient or Legal Guardian Date

The Epworth Sleepiness Scale

Patient Name: _____ **Date:** _____

Date of Birth: _____

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you would have:

- **No chance of dozing =0**
- **Slight chance of dozing =1**
- **Moderate chance of dozing =2**
- **High chance of dozing =3**

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g. a theater or a meeting)	•
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 a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.