

MAPLE SHADE DENTAL GROUP
Patient Information Sheet

PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE) _____
HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____
EMAIL ADDRESS (PERMISSION TO USE FOR APPT REMINDERS, EVENTS, SPECIAL OFFERS) _____
MARITAL STATUS: S / M / D / W / PREFERRED NAME _____
SS# _____ - _____ - _____ DOB ____ / ____ / ____ HOME PHONE _____ - _____ - _____
WORK PHONE _____ - _____ - _____ CELL PHONE _____ - _____ - _____ SEX: M / F /

REFERRAL INFORMATION (PLEASE CIRCLE ONE)

LIVES IN AREA YELLOWPAGES RADIO TV COMMERCIAL WEBSITE OR INTERNET BILLBOARD LOCAL VALUES
INSURANCE CO. WEBSITE NEWSPAPER COUPON TOOTH FAIRY VISIT MAILING TO HOME CANDY BUY BACK
ILLINOIS INSTITUTE OF DENTAL SLEEP MEDICINE EAST PEORIA OFFICE SIGN ON PROPERTY
HOSPITAL/PHYSICIAN REFERRAL _____ FAMILY, FRIEND, CO-WORKER REFERRAL _____

PRIMARY DENTAL INSURANCE COVERAGE

PARENT / EMPLOYEE NAME _____ RELATION TO PATIENT _____
ADDRESS (IF DIFFERENT THAN PT.) _____ CITY _____ STATE _____ ZIP _____
SS# _____ - _____ - _____ EMPLOYER _____ WORK ADDRESS _____
DOB ____ / ____ / ____ WORK PHONE _____ - _____ - _____ OCCUPATION _____
GROUP # _____ INSURANCE CO _____ INS CO ADDRESS _____

SECONDARY DENTAL INSURANCE COVERAGE

PARENT / EMPLOYEE NAME _____ RELATION TO PATIENT _____
ADDRESS (IF DIFFERENT THAN PT.) _____ CITY _____ STATE _____ ZIP _____
SS# _____ - _____ - _____ EMPLOYER _____ WORK ADDRESS _____
DOB ____ / ____ / ____ WORK PHONE _____ - _____ - _____ OCCUPATION _____
GROUP # _____ INSURANCE CO _____ INS CO ADDRESS _____

EMERGENCY CONTACT INFORMATION

PRIMARY CONTACT _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
ALTERNATE PHONE # _____ RELATIONSHIP TO PATIENT _____
SECONDARY CONTACT _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
ALTERNATE PHONE # _____ RELATIONSHIP TO PATIENT _____

MAPLE SHADE DENTAL GROUP

Dental History Form

NAME (LAST, FIRST, MIDDLE) _____ DATE _____

DATE OF LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____ LAST FULL MOUTH XRAYS _____

PREVIOUS DENTIST NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW OFTEN DO YOU: HAVE DENTAL EXAMS? _____ BRUSH YOUR TEETH _____ FLOSS _____

WHAT OTHER DENTAL AIDS DO YOU USE? (SONICARE, BRAUN, TOOTHPICK, PROXYBRUSH, ENDTUFT, ETC) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have active dental problems now?	<input type="checkbox"/>	<input type="checkbox"/>	Clench or Grind your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	If yes, mark all that apply			If yes, When? AM or PM
		Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>	Teeth hit in front first?
		Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Bite your cheek?
		Decay	<input type="checkbox"/>	<input type="checkbox"/>	Smoke a pipe?
		Broken Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Bite your nails?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have trouble with bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	Chew gum?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Bite pencils?
		If yes, Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	Eat sweets?
Have you ever had:			Please answer the following questions:		
<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Have you experienced gum disease or tooth loss?
<input type="checkbox"/>	<input type="checkbox"/>	Oral Surgery or teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any loose teeth or change in your bite?
<input type="checkbox"/>	<input type="checkbox"/>	Periodontal Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to get caught between teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Endodontic Treatment?			If yes, where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Your teeth ground or bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>	Have previous dentists had difficulty getting you numb?
<input type="checkbox"/>	<input type="checkbox"/>	General Anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	Are your jaws sore, especially in the morning?
<input type="checkbox"/>	<input type="checkbox"/>	A broken jaw?	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any mouth odors or bad tastes?
<input type="checkbox"/>	<input type="checkbox"/>	Missing back teeth with no replacement?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced prolonged bleeding either from a cut or dental procedure such as a cleaning?
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone injected into your joints?	<input type="checkbox"/>	<input type="checkbox"/>	Have your teeth ever been involved in an accident or injury?
		If yes, When? _____			If yes, Please state when and what occurred
		How many injections? _____			_____
		By Whom? _____			_____
<input type="checkbox"/>	<input type="checkbox"/>	A bite plate, splint or mouth guard?	<input type="checkbox"/>	<input type="checkbox"/>	Any dental symptoms due to an illness, injury or work related accident?
		If yes, please describe cause			Explain _____
		_____			Place of Accident/Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Full Mouth X-rays?	<input type="checkbox"/>	<input type="checkbox"/>	Date and time of Accident/injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Joint X-rays?			Any dental Symptoms start after this accident or injury?
<input type="checkbox"/>	<input type="checkbox"/>	MRI?			If yes, explain _____
<input type="checkbox"/>	<input type="checkbox"/>	CT Scans? If yes, When? _____			_____
Are any of your teeth sensitive to:					
<input type="checkbox"/>	<input type="checkbox"/>	Hot or cold?			
<input type="checkbox"/>	<input type="checkbox"/>	Biting or chewing?			
<input type="checkbox"/>	<input type="checkbox"/>	Cold sores, blisters, or any other lesions?			

Patient/ Guardian Signature _____ Date _____

Personalized Smile Evaluation

On a scale of 1 to 10, how do you feel about your teeth and smile? 1 2 3 4 5 6 7 8 9 10 😊

Are your teeth crooked or crowded and is that a concern? _____

Do you have spaces between your teeth that bother you? _____

Do you like the color of your teeth? _____

Do you like the shape of your teeth? _____

What would you like to change about the appearance of your smile? _____

Have you ever considered how you might feel with a bright smile? _____



HEALTH HISTORY

Patient's Name: _____

Date: _____

Chief Dental Complaint _____

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health?Y N
2. Has there been any change in your general health in the past year?Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:Y N

6. Height _____ Weight _____

7. DO HAVE OR HAVE YOU EVER HAD:

- A. Rheumatic Fever or Rheumatic Heart Disease?Y N
- B. Congenital Heart Disease?Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?Y N
- E. Seizures, Convulsions, Epilepsy, Fainting or DizzinessY N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?Y N
- G. Liver Disease (Jaundice, Hepatitis)?Y N
- H. Kidney Disease?Y N
- I. Diabetes?Y N
- J. Thyroid Disease (Goiter)?Y N
- K. Arthritis?Y N
- L. Stomach Ulcers or Colitis?Y N
- M. Glaucoma?Y N
- N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?Y N
- O. Radiation (X-ray) treatment for Cancer?Y N
- P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?Y N
- Q. Sinus or Nasal problems?Y N
- R. Any disease, drug or transplant operation that has depressed your immune system?Y N

8. ARE YOU USING ANY OF THE FOLLOWING:

- A. Antibiotics?Y N
- B. Anticoagulants (Blood Thinners)?Y N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?Y N
- D. High Blood Pressure medications?Y N
- E. Steroids (Cortisone, etc.)?Y N

All responses are kept confidential

- F. Tranquilizers?Y N
- G. Insulin or Oral Anti-Diabetic drugs?Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug?Y N
- I. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

- A. Local Anesthesia (Novocaine, etc.)?Y N
- B. Penicillin or other antibiotics?Y N
- C. Sedatives, Barbiturates?Y N
- D. Aspirin or Ibuprofen?Y N
- E. Codeine or other pain killers?Y N
- F. Latex or Rubber Products?Y N
- G. Other allergies or reactions?Y N

10. Do you smoke or chew Tobacco?Y N
How much per day? _____

11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?Y N

12. Have you had any serious problems associated with any previous dental treatment?Y N

13. Have you or an immediate family member had any problem associated with intravenous anesthesia?Y N

14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?Y N

15. Do you wish to talk to the doctor privately about anything?Y N

16. FOR WOMEN ONLY

- A. Are you Pregnant, or **is there any chance** you might be Pregnant?Y N
- B. Are you nursing?Y N
- C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date

Signature of Person Completing Health History

Doctor's Initials

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

Date

Exceptions or changes

Patient's Signature

Doctor's Initials

Date

Exceptions or changes

Patient's Signature

Doctor's Initials

HEALTH HISTORY CONTINUED...

EPWORTH SCALE & AIRWAY EVALUATION

PATIENT NAME _____ AGE _____ DATE _____ DOB _____
 HEIGHT _____ (FT.) WEIGHT _____ (LBS) NECK SIZE _____ (IN) WAIST SIZE _____ (IN)

Using the scale provided, please answer how likely you are to doze off or fall asleep in the following situations:

0 = Would never doze 1 = Slight Chance of Dozing 2 = Moderate Chance of Dozing 3 = High Chance of Dozing

ACTIVITY	SCORE
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	_____

Please mark if you suffer from or have been told you have any of the following:

- | | | |
|---------------------------------|------------------------------------|-------------------------------|
| _____ Loud Snoring | _____ Frequent Nighttime Urination | _____ Daytime Tiredness |
| _____ Diabetes | _____ Witnessed Apnea | _____ COPD |
| _____ Depression | _____ Obesity/ Weight Gain | _____ Thyroid Dysfunction |
| _____ Acid Reflux | _____ Lack of Energy | _____ Never Feel Rested |
| _____ CPAP Intolerance | _____ Wake up Coughing | _____ High Blood Pressure |
| _____ Lack of Energy | _____ Morning Headaches | _____ Decreased Concentration |
| For Women Only: | | |
| _____ Premenopausal | _____ Pregnant | _____ Postmenopausal |
| _____ Polycystic Ovary Syndrome | _____ Hysterectomy | |

SIGNS & SYMPTOMS OF TMJ (Please check all symptoms that apply)

- HEADACHES
- JAW JOINT PAIN
- JAW JOINT NOISE OR CLICKING
- LIMITED MOUTH OPENING
- EAR CONGESTION
- DIZZINESS
- RINGING IN EARS
- DIFFICULTY SWALLOWING
- LOOSE TEETH
- CLENCHING OR GRINDING
- FACIAL PAIN
- SENSITIVE TEETH
- CHEWING DIFFICULTIES
- NECK PAIN
- POSTURAL PROBLEMS
- TINGLING IN FINGERTIPS
- HOT & COLD TEETH SENSITIVITY
- NERVOUSNESS OR INSOMNIA

Head Pain, Headache

- Forehead
- Temples
- "Migraine" type
- Sinus type
- Shooting pain up back of head
- Hair and/or scalp painful to touch

Ear Problems

- Hissing, buzzing or ringing
- Decreased hearing
- Ear pain, ear ache, no infection
- Clogged, "itchy" ears
- Vertigo, dizziness

Jaw Problems

- Clicking, popping jaw joints
- Grating sounds
- Pain in cheek muscles
- Uncontrollable jaw and/or tongue movements

Neck Problems

- Lack of mobility, stiffness
- Neck pain
- Tired, sore muscles
- Shoulder aches and backaches
- Arm and finger numbness and/or pain

Eyes

- Pain behind eyes
- Bloodshot eyes
- May bulge out
- Sensitive to sunlight

Mouth

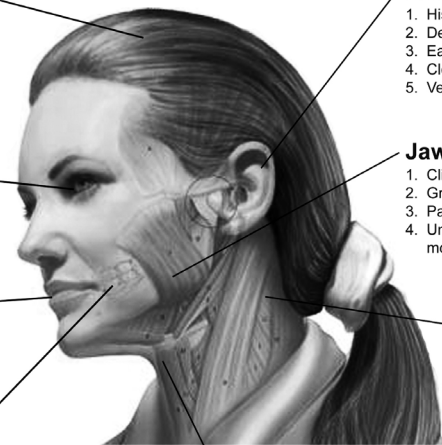
- Discomfort
- Limited opening of mouth
- Inability to open smoothly
- Jaw deviates to one side when opening
- Locks shut or open
- Can't find bite

Teeth

- Clenching, grinding at night
- Looseness and soreness of back teeth

Throat

- Swallowing difficulties
- Laryngitis
- Sore throat with no infection
- Voice irregularities or changes
- Frequent coughing or constant clearing of throat
- Feeling of foreign object in throat constantly



Office Use: Doctor Team _____ Patient Phone Number _____

- Patient scheduled an appt with IIDSMS Patient wants to be called by IIDSMS Does not want to be contacted about Epworth/TMJ Results

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of \$30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month or 18% APR
Collections fees (up to 42% of the full balance)
Legal fees for collection services

Signature of Patient or Guardian

Date

Print Name

Witnessed By

Patient Consent to receive Mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

Email Address *(please print)*

Do we have your permission to:

Send a recall appointment reminder to your home? Y____ N____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y____ N____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

Signature of Patient / Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

Signature of Patient / Parent or Legal Guardian Date