AESTHETIC
FAMILY DENTAL CENTER

PATIENT INFORMATION

Patient Name _____ , _____ _____
Last Name First Name MI

Address _____

City _____ State _____ Zip Code _____

Social Security # _____-_____-_____ Birth Date _____

Sex ☐ Male ☐ Female ☐ Non-binary

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Patient Employer/ School _____

Occupation _____

Employer Phone # _____

CONTACT INFORMATION

Home (_____)_____

Cell (_____)_____

Work (_____) _____ EXT _____

Email Address:

_____

Best time to reach you:

☐ AM ☐ Lunch ☐ PM

In Case of emergency, Contact

Name _____

Relationship _____

Phone (_____) _____

DENTAL INSURANCE

Insurance Company _____ Employer _____

Member ID: _____Group # _____

Subscribers Name (if different than above) _____ Social Security # _____-_____-_____

Birth Date _____

Is the patient covered by additional insurance? ☐Yes ☐No (If yes then complete the following)

Subscribers Name _____ Birthdate _____

SS# _____ Relationship to patient _____

Insurance Company _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Michael Hansen and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Aesthetic Family Dental may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of abstaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, or Guardian _____ Date _____

DENTAL HISTORY

Reason for today's visit / Dental Concerns:

_____

_____

Former Dentist _____

Date of last dental visit _____

Date of last dental X-Rays _____

AESTHETIC
FAMILY DENTAL CENTER

MEDICAL HISTORY

Patient Name_____ Date _____

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

Are you under a physician's care now? Yes ☐ No ☐ If yes, please explain_____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ If yes, please explain_____

Have you ever had a serious head or neck injury? Yes ☐ No ☐ If yes, please explain_____

Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐ If yes, please explain_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes ☐ No ☐ If yes, please explain _____

Are you on a special diet? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

Women: Are you

☐ Pregnant ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If other, please explain_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Yes ☐No	Cortisone Medicine	☐Yes ☐No	Hemophilia	☐Yes ☐No	Radiation Treatments	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Anemia	☐Yes ☐No	Easily Winded	☐Yes ☐No	Herpes	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Emphysema	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Rheumatism	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Scarlet fever	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Shingles	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Sickle cell Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Blood Disease	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Leukemia	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Liver Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Swelling Limbs	☐Yes ☐No
Cancer	☐Yes ☐No	Glaucoma	☐Yes ☐No	Lung Disease	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hay Fever	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Chest Pains	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Convulsions	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Venereal Disease	☐Yes ☐No

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain_____

MEDICATIONS – List any medications you are currently taking and the correlating diagnosis:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____ DATE_____

AESTHETIC
FAMILY DENTAL CENTER

Epworth Sleepiness Scale

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 you would have:

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

Circle the number corresponding to your choice in the right-hand column. Total your score below.

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for an hour	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

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 seek medical attention.

AESTHETIC
FAMILY DENTAL CENTER

TMJ Evaluation

Name _____ **Date**_____

List any symptoms since your last visit that you want to bring to our attention:

_____

_____

_____

Indicate your current degree of pain level by circling the corresponding number:

Chief Complaint:	No Pain	Mild				Moderate		Severe			Worse Possibl
TMJ Clicking/Grating	0	1	2	3	4	5	6	7	8	9	10
TMJ locking/Stiffness	0	1	2	3	4	5	6	7	8	9	10
Inability to open mouth	0	1	2	3	4	5	6	7	8	9	10
Mouth doesn't open straight	0	1	2	3	4	5	6	7	8	9	10
Pain in jaw when eating	0	1	2	3	4	5	6	7	8	9	10
Unstable bite	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
Face Pain	0	1	2	3	4	5	6	7	8	9	10
Ear Pain/ Stiffness	0	1	2	3	4	5	6	7	8	9	10
Ringing in ears	0	1	2	3	4	5	6	7	8	9	10
Difficulty swallowing	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Face muscle fatigue	0	1	2	3	4	5	6	7	8	9	10
Other _____	0	1	2	3	4	5	6	7	8	9	10

Have you previously been treated for TMJ related pain or issues? If so, please explain:

_____

_____

_____

AESTHETIC
FAMILY DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE

Name: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed: _____
_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____Date: _____