Midlothian Dental Arts

151 Le Gordon Drive, Suite 100
Midlothian, VA 23114
(804)379-9177

WELCOME TO OUR PRACTICE!

Our goal is to help you to reach and maintain maximum oral health. Please fill out paperwork completely. The better we communicate, the better we can care for you.

Today's Date: _____ Whom may we thank for referring you? _____

Name: _____ I prefer to be called: _____
First M. Last

_____Single____Married____Divorced____Widowed ___Male ___Female Date of Birth: _____

SSN: ____-____-____ Home #: ____-____-____ Cell #____-____-____ Work #____-____-_____

Home Address _____City_____State_____Zip_____

Email Address_____@_____

Do we see other family members: ____Yes___ No If so who? _____

Employer_____Occupation:

_____

Address_____Phone Number:_____

Spouse Name_____ Date of Birth_____SSN:____-____-_____

Employer_____Work #____-____-____ Cell # ____-_____-_____

In the event of an emergency, is there someone whom we should contact other than your spouse?

Name:_____Relation:_____Phone Number:_____

DENTAL INSURANCE:_____Policy Holder Name:_____

Date of Birth:_____SSN/ID Number:_____Group #_____

Relationship to patient:_____Employer:_____

Ins. Co. Address:_____Phone #_____

If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage your insurance provides. We accept most insurance companies. You are responsible for your deductible and the portion the insurance does not cover at the time of service provided. REMEMBER HOWEVER, YOU ARE RESPONSIBLE FOR THE TOTAL TREATMENT FEE REGARDLESS OF WHAT WE MIGHT CALCULATE AS YOUR PROTION, IF FOR ANY REASON THE INSURANCE DOES NOT HONOR THEIR COMMITMENT TO YOU OR TO US.

CONTRACTUAL AGREEMENT: PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

I understand all patient portions are due payable at the time services are rendered. I authorize payment directly to Dr. Jeryl Abbott, D.D.S. for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the above-named patient and any insurance payments (sent to the office or if sent to me, I will forward to the office) will be credited to the account. In the event the bank returns any check given in payment on this account unpaid for any reason a $30.00 charge will be added to the account balance each time a check is returned. If all charges are not paid in full within sixty (60) days from the date of service I agree to pay the service charge of (18%) per month, (21%) annual interest on the unpaid balance, along with a $5.00 late charge. If this account is referred to a collection agency/attorney for collection, I agree to pay all cost of collection, including, but not limited to, an additional 33% of the total balance owed for collection costs, along with any attorney fees and all court costs. I further understand that I will be charged a minimum fee of $25.00 per one half hour for all missed or canceled appointments unless a 48-hour notice is given.

Name_____Relationship to Patient_____Date:_____

Signature_____Witness_____Date_____

Employee of Midlothian Dental Arts

Medical Information:

Physician's name: _____Phone #_____

Date of last visit: _____ Current physical health (circle one) Good Fair Poor

Are you currently under the care of a physician? _____ If yes, explain reason_____

Are you taking any medication? _____ If so, please list each one _____

For Women:

Are you taking birth control pills: _____ Are you nursing? _____ Are you pregnant: _____ Week #_____

Have you ever had any of the following medical conditions? (Please circle Y or N for each)

IT IS IMPROTANT THAT YOU ALERT US OF ALL OUR MEDICAL CONDITIONS.

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Colitis
Y N Dental Anxiety
Y N Diabetes
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Murmur
Y N Heart Trouble
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N HIV/AIDS +
Y N Kidney Problems
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic Fever
Y N Shingles
Y N Sinus Problems
Y N Thyroid Condition
Y N Tobacco Use (____ a day)
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease
Y N Other

Please explain any conditions that you have answered yes to indicated above: _____

_____

_____

_____

Are you allergic to any of the following: (Please circle Y or N for each)?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

AUTHORIZATION:

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.

Signature: _____ Date: _____

Print Patient Name: _____ Relationship to Patient_____

OFFICE USE ONLY: I verbally reviewed the medical information above with the patient named herein.

Initials_____Date_____

DENTAL HISTORY

Name: _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist: _____ How long have you been a patient? _____

Date of most recent dental exam: _____ Date of most recent x-rays:

Date of most recent treatment (other than cleaning): _____

I routinely see the dentist every: 3 months 4 months 6 months 12 months Not routinely

What is your immediate concern? _____

Please answer yes or no to the following:

	YES	NO
Personal History		
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)?	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or have your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
Smile Characteristics		
1. Is there anything about the appearance of your teeth you would like to change?	☐	☐
2. Have you ever whitened (bleached) your teeth?	☐	☐
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
4. Have you been disappointed with the appearance of previous dental work?	☐	☐
Bite & Jaw Joint		
1. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping)	☐	☐
2. Do you/would you have any problems chewing gum?	☐	☐
3. Do you/would you have any problems chewing bagels, baguettes, protien bars, or, other hard foods?	☐	☐
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
5. Are your teeth crowding or developing spaces?	☐	☐
6. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
7. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	☐	☐
8. Do you clench your teeth in the daytime or do they become sore?	☐	☐
9. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
10. Do you wear or have you ever worn a bite appliance?	☐	☐
Tooth Structure		
1. Have you had any cavities within the past 3 years?	☐	☐
2. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food?	☐	☐
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
5. Do you have any grooves or notches on your teeth near the gum line?	☐	☐
6. Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling?	☐	☐
7. Do you frequently get food caught between any teeth?	☐	☐
Biology		
1. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
3. Have you ever noticed an unpleasant odor in your mouth?	☐	☐
4. Is there anyone with a history of periodontal disease in your family?	☐	☐
5. Have you ever noticed gum recession?	☐	☐
6. Have you ever had any teeth become loose on their own (no injury), or do you have difficulty eating an apple?	☐	☐
7. Have you experienced a burning sensation in your mouth?	☐	☐

HIPAA PRIVACY RIGHTS FORM

I have explained to the patient, _____, that disclosures may be made to family and friends related to the patient's health or as needed for payment of dental services. I have explained that we will only disclose information relevant to current treatment. Our patient has agreed that we may disclose healthcare information in person or by telephone to:

_____

_____

_____

_____

_____

Patient/Guardian Signature: _____

Date: _____

SLEEP SCREENING QUESTIONNAIRE

EPWORTH SLEEPINESS SCALE

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

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze **1 = Slight chance of dozing**

2 = Moderate chance of dozing **3 = High chance of dozing**

SITUATION

Sitting and reading _____
Watching television _____
Sitting inactive in a public place (i.e. theater) _____
As a car passenger for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting and talking to someone _____
Sitting quietly after lunch without alcohol _____
In a car, while stopping for a few minutes in traffic _____

TOTAL SCORE _____

A score of 8 or greater indicates the possibility of sleep disordered breathing.

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner.)

0 = Never **1 = Infrequently (1 night per week)**

2 = Frequently (2-3 nights per week) **3 = Most of the time (4 or more nights per week)**

My snoring affects my relationship with my partner _____
My snoring requires us to sleep in separate rooms _____
My snoring is loud _____
My snoring affects people when I am sleeping away from home (i.e. hotel, camping, etc.) _____

TOTAL SCORE _____

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.

PATIENT NAME _____ **DATE:** _____

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