Eleven Eighty Seven
DENTAL

PATIENT INFORMATION

Date: _____

First name: _____ Last name:_____Middle Initial:___
Address: _____ City: _____State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: ☐Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date:_____ Occupation: _____
Email: _____ Employment Status: ☐ Full time ☐ Part Time ☐ Retired
Closest Relative or Friend: _____ Phone: _____
Primary Physician: _____ Phone: _____
Dentist: _____ Phone: _____
Date & type of last dental X-rays: _____

MEDICAL HISTORY

Are you under a physician's care now? ☐Yes ☐ No
Have you ever had a serious head or neck injury? ☐Yes ☐No
Do you or have you taken anticoagulants (blood thinners) ☐Yes ☐No
Are you on a special diet? ☐Yes ☐No
Do you use controlled substances? ☐ Yes ☐No
Women: Are you pregnant, trying to get pregnant, or nursing? ☐Yes ☐No

Do you have or have you had any of the following? Answer Yes or No, please **DO NOT** leave blank.

AIDS/HIV Positive	☐Yes	☐No	Depression/Bipolar	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Alcoholism	☐Yes	☐No	Diabetes	☐Yes	☐No	Leukemia	☐Yes	☐No
Allergy/Anaphylaxis	☐Yes	☐No	Drug Addiction	☐Yes	☐No	Liver Disease	☐Yes	☐No
Alzheimer's Disease	☐Yes	☐No	Eating Disorder	☐Yes	☐No	Low blood sugar	☐Yes	☐No
Anemia	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	Nervousness/Anxiety	☐Yes	☐No
Angina	☐Yes	☐No	Excessive Bleeding	☐Yes	☐No	Osteoarthritis	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Fainting/Dizziness	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Artificial Joint	☐Yes	☐No	Head/ neck/back pain	☐Yes	☐No	Psychiatric Condition	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Attack/Failure	☐Yes	☐No	Radiation Treatments	☐Yes	☐No
Autoimmune Disease	☐Yes	☐No	Heart Condition/Defect	☐Yes	☐No	Renal Dialysis	☐Yes	☐No
Breathing Problem	☐Yes	☐No	Heart Pacemaker	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Cancer	☐Yes	☐No	Hepatitis	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Chemotherapy	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Chest Pains/Angina	☐Yes	☐No	Human Papilloma Virus	☐Yes	☐No	Stroke	☐Yes	☐No
Cold Sore/Fever Blister	☐Yes	☐No	Gastrointestinal Issue	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Cortisone Medicine	☐Yes	☐No				Tuberculosis	☐Yes	☐N

MEDICATION QUESTIONNAIRE

Please list all medications that you take, including prescription, herbal, and over-the counter.

Medications	Reason taking	Office use only

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other:

If yes, type of reaction:

Please describe any serious illness, injury, hospitalization, or surgery not listed that you think we should know about.

DENTAL QUESTIONNAIRE

Smoke or use smokeless tobacco	☐Yes	☐No	Brush at least once each day	☐Yes	☐No
Bite/chew lips or cheeks	☐Yes	☐No	Use fluoride toothpaste	☐Yes	☐No
Have dentures that fit poorly	☐Yes	☐No	Floss at least once each day	☐Yes	☐No
Have a history of oral cancer	☐Yes	☐No	Drink tap water that has fluoride	☐Yes	☐No
Have frequent dry mouth	☐Yes	☐No	Drink bottled water only	☐Yes	☐No
Clench or grind teeth	☐Yes	☐No	Have regular dental visits	☐Yes	☐No
Need to improve vitamin intake	☐Yes	☐No	Have dental implants	☐Yes	☐No
Have a family history of gum disease	☐Yes	☐No	Have chronic TMJ (jaw) problems	☐Yes	☐No
Gums bleed when brushing or flossing	☐Yes	☐No	Have oral piercing(s)	☐Yes	☐No
Have more than 2 alcohol drinks x day	☐Yes	☐No	When you play contact sports, do you use a mouth guard?	☐Yes	☐No ☐ Not applicable
Use alcohol-based mouth rinse	☐Yes	☐No			

Have you had a bad experience in the dental office ☐Yes ☐No

Are you nervous about having dental treatment? ☐Yes ☐No

Are you having oral pain or dental discomfort at this time? ☐Yes ☐No

What type of toothbrush do you use? Soft____Medium____Hard_____ What toothpaste do you use?_____

What other hygiene aids do you use? _____

What is the main reason for your visit today?_____

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 Eleven Eighty Seven Dental of any changes in medical status. If patients are under 18 years of age, we ask that parent/guardian stay in the office while treatment is rendered. Parent/Guardian must sign for patient's under 18 years of age. X_____

Witness sig. X_____

ELEVENEIGHTYSEVEN
DENTAL
DR. MICHAEL J. REZSOFI, D.D.S
109 LARSON LANE SUITE 300
ALEDO, TX 76008
PHONE: (817) 441-8870
FAX: (817) 441-8874
1187DENTAL@GMAIL.COM

Appointments and Cancellations Policy

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $50 charge for not showing up for scheduled appointments and canceling the same day of your appointments. ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Patient/Parent Signature _____

Print Name _____

ElevenEightySeven
Dental
dr. michael j. rezsofi, d.d.s
109 Larson Lane Suite 300
Aledo, TX 76008
phone: (817) 441-8870
fax: (817) 441-8874
1187dental@gmail.com

Dr. Michael J. Rezsofi

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.

Please Print Name
+

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

ELEVENEIGHTYSEVEN
DENTAL
DR. MICHAEL J. REZSOFI, D.D.S
109 LARSON LANE SUITE 300
ALEDO, TX 76008
PHONE: (817)441-8870
FAX: (817)441-8874
1187DENTAL@GMAIL.COM

Patient Information

Height: _____inches

Weight_____lbs

Age____

Male/Female

Patient Questions

1. Do you snore loudly enough to be heard in the next room? Y / N
2. Do you often feel tired during the day? Y / N
3. Has anyone observe that you stop breathing while asleep? Y / N
4. Do you have high blood pressure or are taking medication for it? Y / N
5. Do you have a body-mass index (BMI) greater than 35? Y / N
6. Do you have a neck circumference greater than 40 cm/ 15.75in? Y / N
7. Are you age 50 or older? Y / N
8. Are you male? Y / N

Patients answering "yes" to three or more of the above questions are at a high risk for OSA and should be referred to a physician.

**Measurement should be taken by dental staff with patient's consent*

Source: American Sleep Apnea Association