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 _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

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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