

Promenade Dental
26800 S Tamiami Trl #350
Bonita Springs, FL 34134
Tel: 239-676-9696

Patient Information

Patient Name: _____ Date _____
Last, First MI (Preferred Name) Gender: _____ Married – Single – Child - Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Email Address: _____

Address: _____
Street Apartment #

_____ City State Zip Code

Health Information

Date of Last Dental Visit _____ Reason for that visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

List **all** medications, vitamins & over the counter medications you are taking: _____

- Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____
- Are you now under the care of a physician? Yes No
 If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party



Promenade Dental
26800 S Tamiami Trail #350
Bonita Springs, FL 34134

HEAD HEALTH HISTORY QUESTIONNAIRE

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PATIENT INFORMATION

NAME	DATE TODAY / /	AGE	SEX	TELEPHONE
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Please review and answer all parts of each question with our staff. Provide specific details/notes in the righthand column.

#	QUESTIONS	ANSWERS		NOTES - LIST QUESTION #, THEN DESCRIBE SYMPTOM DETAILS
1	Have you noticed a change in your bite? » Do you feel like your teeth hit first on the right or left side? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT » Do you hit more on the front teeth or more on the back teeth? <input type="checkbox"/> FRONT <input type="checkbox"/> BACK	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2	Are you aware of any of the following: Popping/Clicking Grinding Noise in the Jaw Joints	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO	
3	Do you have difficulty or pain <input type="checkbox"/> opening wide <input type="checkbox"/> chewing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4	When you wake up, do your jaw joint or muscles feel tight or sore?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
5	Do you snore at night?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
6	Does your jaw joint or muscles feel stiff, tight or tired after eating?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
7	Do you grind or clench your teeth <input type="checkbox"/> at night <input type="checkbox"/> during the day?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
8	Do your gums bleed after <input type="checkbox"/> brushing <input type="checkbox"/> flossing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
9	Do you experience pain in your: Jaw Face Neck Shoulder and/or Arms	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO	
10	Do you get <input type="checkbox"/> headaches <input type="checkbox"/> migraines? » If Yes, what time of day do they occur? <input type="checkbox"/> MORNING <input type="checkbox"/> AFTERNOON <input type="checkbox"/> NIGHT <input type="checkbox"/> ANYTIME » How many headaches (H) and migraines (M) each week? ____ (H) / ____ (M) Each month? ____ (H) / ____ (M) » What medications do you take to relieve them? _____ » How long do they last without medications? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
11	Do you have any <input type="checkbox"/> ringing <input type="checkbox"/> fullness in your ears?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
12	Do you ever get <input type="checkbox"/> dizzy <input type="checkbox"/> sea sick?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
13	Do you ever feel <input type="checkbox"/> anxiety <input type="checkbox"/> stressed? » How would you rate your stress level? <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14	Have you had braces or orthodontic treatment? » If Yes, when did you finish your treatment? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
15	Have you ever worn a <input type="checkbox"/> bite splint <input type="checkbox"/> retainer? » If Yes, when did you have this treatment? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
16	Have you ever had a <input type="checkbox"/> car accident <input type="checkbox"/> trauma to your head? » If Yes, describe and list dates: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
17	Have you ever had any sports injuries? » If Yes, describe and list dates: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
18	Do you restrict or avoid normal activities due to pain or symptoms? » If Yes, describe activities: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
19	Do you spend 4+ hours working at a desk or using a computer daily?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

Scoring: 1-3 "Yes" Responses = Mild unbalanced bite | 4-6 "Yes" Responses = Moderate unbalanced bite | 7+ "Yes" Responses = Severe unbalanced bite

When finished, please return to our office and review your answers with our staff.

Promenade Dental

Obstructive Sleep Apnea Screening

Patient Name: _____	Date: _____
Do you Snore?	___ Yes ___ No
Are you tired, fatigued or sleepy during the day?	___ Yes ___ No
Do you have high blood pressure?	___ Yes ___ No
Do you ever choke or gasp while you sleep?	___ Yes ___ No
Have you had an overnight sleep study?	___ Yes ___ No

Staff Use Only

Patient History:

Physical Exam: (indicate all that are present)

<input type="checkbox"/> Elongated, Misshaped Uvula	<input type="checkbox"/> Bruxism	<input type="checkbox"/> Class II Occlusion
<input type="checkbox"/> Scalloped/Large Tongue	<input type="checkbox"/> Tori Present	<input type="checkbox"/> Lg Tonsils
<input type="checkbox"/> Signs of Acid Reflux	<input type="checkbox"/> Narrow Airway	

Snoring disrupt patients or partner's sleep? ___ Yes ___ No
Patient concerned about sleepiness/tiredness? ___ Yes ___ No
Patient concerned about OSA risk? ___ Yes ___ No

Patient prescribed CPAP? ___ Yes ___ No If yes, does patient use CPAP? ___ Yes ___ No

Patient Notes: _____ Staff Initials _____

Doctor's Initial Evaluation:

<input type="checkbox"/> Hypertension (401.9)	<input type="checkbox"/> Suspected Sleep Apnea (327.23)	<input type="checkbox"/> Fatigue (780.79)
<input type="checkbox"/> Snoring (786.09)	<input type="checkbox"/> Witnessed Apneas	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Obesity (278.00)	<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Other _____

Recommended Next Steps:

Diagnostic Sleep Test Oral Appliance Consultation Referral to ENT/Specialist

Doctor Signature: _____ Date: _____

Patient Signature: _____ Date: _____