Blueberry Dental

Dr. Ewelina Kalinowska-Szyszka D.D.S.
510 East Tarpon Avenue, Tarpon Springs, 34689
Phone: (727) 938-9200 Fax: (727) 938-9220

Patient Registration Form **Today's Date: _____**

Is the Patient the Responsible Party: YES NO → IF NO, Your Name:_____

Your Relationship to Patient: _____

TREATED PATIENT INFORMATION

First Name: _____ Last Name: _____ M.I. ___

Date of Birth: _____ / _____ / _____ SSN: _____ - _____ - _____

Street Address /P.O. BOX: _____

City, State : _____ ZIP Code: _____

Employment Status: PART-TIME FULL-TIME RETIRED Sex: MALE FEMALE

Student Status (If applicable): PART-TIME FULL-TIME

Marital Status: MARRIED SINGLE DIVORCED SEPARATED WIDOWED

Primary Reason for Visit: _____

CONTACT INFORMATION

Home Phone: (_____) _____ - _____ Do you consent to us leaving voicemails? YES NO

Cellular: (_____) _____ - _____ I would like to receive text message reminders: YES NO

Email: _____ I would like to receive correspondence via e-mail: YES NO

Emergency Contact:

Name: _____

Relationship: _____

Phone#: (_____) _____ - _____

INSURANCE INFO

Using Dental Insurance? YES NO → IF YES, Is the Treated Patient the Primary Subscriber on the Policy? YES NO

ONLY IF PATIENT IS NOT PRIMARY SUBSCRIBER: Full Name, Date of Birth of Primary Subscriber?

Full Name: _____ D.O.B. _____

Insurance Company: _____

Insurance Phone#(On Card): _____

Group Number: _____

Member #ID: _____

Signature of Patient, or Legal Guardian: _____Date: _____

(Office) Witness of signature: _____Date: _____

Ewelina Szyszka, DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
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/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, 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 of 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
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 _____

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Our mission is to provide patients with the highest quality of care in a safe, efficient, and comfortable environment.

Patient Information and Consent

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to my medical history, medications, or health status. I authorize the dental staff to perform any necessary diagnostic procedures, including but not limited to dental radiographs (x-rays), study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to establish an accurate diagnosis. I further authorize the doctor, and qualified staff acting under the doctor's supervision when appropriate, to perform dental treatment, administer medications, and provide therapy as part of my diagnosis and treatment plan with my informed consent. I understand that even if I have dental insurance coverage, I remain financially responsible for all services rendered. Unless other financial arrangements are made in advance, payment is due at the time services are provided.

Financial Agreement & Payment Policy: Thank you for choosing Blueberry Dental for your dental care. Our goal is to provide high-quality treatment while maintaining transparency regarding financial responsibilities. By signing below, you acknowledge and agree to the policies contained in this agreement.

Insurance: As a courtesy, we will submit claims to your dental insurance and may accept assignment of benefits when permitted.

• You must provide accurate and complete insurance information.
• Insurance estimates are not guarantees of payment. Coverage, benefit amounts, limitations, exclusions, waiting periods, downgrades, and frequency limits are determined solely by your insurance plan.
• Your insurance policy is a contract between you, your employer (if applicable), and the insurance company.
• You are financially responsible for all charges, including any portion not paid by insurance for any reason.
• Deductibles, co-payments, and estimated patient portions are due at the time services are rendered unless other arrangements are made in advance.

Payment: Payment for services is due at the time of treatment unless prior financial arrangements have been made. We accept cash, personal checks, and major credit/debit cards (Visa, MasterCard, Discover, American Express). Any remaining balance after insurance processing will be billed to the patient and payment is due within thirty (30) days of the statement date. We submit claims for dental insurance only and do not bill medical insurance.

Patients Without Insurance: Patients without dental insurance are responsible for full payment at the time services are provided. Written fee estimates are available upon request.

Minor Patients: A parent or legal guardian accompanying a minor is responsible for payment at the time of service. Our office does not become involved in financial arrangements between parents or guardians.

Missed or Broken Appointments: Appointments cancelled or rescheduled with less than 24 hours' notice may be considered missed appointments. A $50 missed appointment fee may be charged.

Returned Payments: A $25 fee will be applied to any check returned by the bank.

Overdue Accounts & Collections: Accounts with balances more than ninety (90) days past due may be referred to a collection agency or attorney. The patient agrees to be responsible for all reasonable collection costs, including interest, collection fees, attorney's fees, and court costs to the extent permitted by Florida law.

Records & Radiographs: Patient records, including radiographs, are the property of Blueberry Dental as permitted by law. Copies may be provided upon written request and payment of any applicable duplication fees permitted under Florida law.

Acknowledgment & Assignment of Benefits: I certify that the insurance information I have provided is accurate and complete. I authorize the release of information necessary to process insurance claims and authorize payment of benefits directly to Blueberry Dental where applicable.

I acknowledge that I have read, understand, and agree to this Patient Consent, Payment Policy, and Financial Agreement and accept full financial responsibility for services provided.

HIPPA: Consent to share appointment/billing/dental information with the person named below:

NAME: _____

RELATIONSHIP: _____

I have read the attached pamphlet, titled the Notice of Privacy Practices (HIPPA), effective date of July 2023?

YES NO

I have read the pamphlet attached, titled "My Insurance Covers This, Right?"

YES NO

Patient's Name (printed): _____

Signature of Patient, or Legal Guardian: _____ **Date:** _____

(Office) Witness of signature: _____ **Date:** _____

BLUEBERRY DENTAL Sleep Health Screening

This brief screening helps our clinical team understand your sleep patterns and determine whether dental care, including a custom oral appliance, may benefit your overall health. Please answer each question to the best of your knowledge. All information you provide is kept confidential and reviewed only by your care team.

1. Patient Information

Full name	**Date of birth**
Today's date	**Phone**
Email	**Preferred language**

Primary care doctor	

2. STOP-BANG Sleep Apnea Screening

Check Yes or No for each. There are no right or wrong answers.

	Question	Yes	No
S	**Snoring** Do you snore loudly enough to be heard through a closed door, or loud enough that your bed partner elbows you?	☐ Y	☐ N
T	**Tired** Do you often feel tired, fatigued, or sleepy during the daytime even after a full night of sleep?	☐ Y	☐ N
O	**Observed** Has anyone ever told you that you stop breathing, gasp, or choke during sleep?	☐ Y	☐ N
P	**Pressure** Do you have high blood pressure, or are you being treated for it?	☐ Y	☐ N
B	**BMI** Is your body mass index more than 35? (Our team can help you check.)	☐ Y	☐ N
A	**Age** Are you over 50 years old?	☐ Y	☐ N
N	**Neck** Is your neck circumference more than 17 inches (men) or 16 inches (women)? (We can measure.)	☐ Y	☐ N
G	**Gender** Are you male?	☐ Y	☐ N
For our team: Total Yes: ____ / 8 Risk: ☐ Low (0-2) ☐ Intermediate (3-4) ☐ High (5-8)			

3. Epworth Sleepiness Scale

How likely are you to doze off in each situation? Use the scale below.

0 never **1** slight **2** moderate **3** high chance of dozing

	Situation	0	1	2	3
1	Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
2	Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3	Sitting inactive in a public place (church, movie, meeting)	☐ 0	☐ 1	☐ 2	☐ 3
4	As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5	Lying down to rest in the afternoon when possible	☐ 0	☐ 1	☐ 2	☐ 3
6	Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
7	Sitting quietly after lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8	In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
For our team: Total: ____ / 24 ☐ 0-7 normal ☐ 8-9 mild ☐ 10-15 moderate ☐ 16+ severe					

4. Sleep History

Ever had a sleep study?	☐ Y ☐ N	Diagnosed with sleep apnea?	☐ Y ☐ N ☐ ?
Currently use CPAP?	☐ Y ☐ N	CPAP comfort?	☐ Easy ☐ OK ☐ Hard
Wake with dry mouth or sore throat?	☐ Often ☐ Some ☐ Rare	Wake with morning headaches?	☐ Often ☐ Some ☐ Rare
Grind or clench teeth at night?	☐ Y ☐ N ☐ ?	Jaw pain, clicking, or popping?	☐ Y ☐ N
Trouble breathing through nose?	☐ Y ☐ N ☐ Some	Frequent allergies or congestion?	☐ Y ☐ N
Take sleep aids or sedatives?	☐ Y ☐ N	Restless sleep or kicking at night?	☐ Y ☐ N ☐ ?

5. Dental Status (for oral appliance fit)

Have most natural teeth?	☐ Yes ☐ Some missing ☐ Few/none	Wear dentures or partials?	☐ Upper ☐ Lower ☐ Partial ☐ None
Loose teeth or recent dental work?	☐ Y ☐ N	Worn a night guard or mouthpiece?	☐ Y ☐ N

6. Brief Medical History

Check any that apply.

☐ High blood pressure ☐ Heart disease / AFib ☐ Stroke or TIA ☐ Diabetes

☐ Acid reflux (GERD) ☐ Asthma or COPD ☐ Depression / anxiety ☐ Thyroid disorder

Current medications:

7. Consent and Signature

I understand that this questionnaire helps my dental team evaluate my sleep health and discuss whether further evaluation or treatment, including a custom oral appliance, may be appropriate. This is a screening tool and is not a diagnosis. Diagnosis of obstructive sleep apnea must be made by a qualified physician, often based on a sleep study. I agree that Blueberry Dental may share relevant findings with my physician or sleep specialist for my care. I confirm the answers above are accurate to the best of my knowledge.

Patient signature	Date	Reviewed by (team)	Date

Thank you for trusting us with your care.

If you have any questions about next steps, please ask any member of our team.