HEALTH HISTORY FORM

Email: _____ **Today's Date:** / /

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PERSONAL INFORMATION

Full Name :

(PLEASE USE CAPITAL)

Home Phone : _____ **Business/Cell Phone** : _____

Address : _____

Ocupation : _____ **Height** : **Weight** :

Date of Birth : _____ **Social Security Number** : _____

Sex : ☐ M ☐ F

Emergency Contact : _____ **Relationship** : _____

Home Phone : _____ **Cell Phone** : _____

If you are completing this form for another person, what is your name *and* relationship to that person? : _____

Do you have any of the following diseases or problems: (check DK if you don't know the answer to the question)	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

***If you answered yes to any of the 4 items above, please stop and return this form to the receptionist.**

DENTAL INFORMATION

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatment?	☐	☐	☐
Have you ever had braces?	☐	☐	☐
Have you ever had problems associated with previous dental treatment?	☐	☐	☐
Is your home water fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Daily ☐ Weekly ☐ Ocasionally ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have mouth sores or ulcers?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: .....

What was done at that time? .....

.....

What is the reason for your dental visit today? .....

How do you feel about your smile? .....

MEDICAL INFORMATION

Please mark your response to indicate if you have or have not had any of the following diseases or problems.	**Yes**	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician's name : ..... Phone: .....

Address/City/State/Zip: .....

Are you in good health?	☐	☐	☐

HEALTH HISTORY FORM

MEDICAL INFORMATION

Has there any change in your general health within the past year? Yes ☐ No ☐ DK ☐

If yes, what condition is being treated? .....

Date of last physical exam .....

Are you taking or have recently taken any prescription or over the counter medicine (s)? Yes ☐ No ☐ DK ☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: .....

.....

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes ☐ No ☐ DK ☐

If yes, what was the illness or problem? .....

.....

Do you wear contact lenses? Yes ☐ No ☐ DK ☐

Joint Replacement Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐

Date: if yes, have you had complications? .....

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐ DK ☐

Date Treatment began: .....

Do you use controlled substances (drugs)? Yes ☐ No ☐ DK ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ☐ No ☐ DK ☐

If so, how interested are you in stopping?

Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes ☐ No ☐ DK ☐

If yes, how much alcohol did you drink the last 24 hours? .....

If yes, how much do you typically drink in a week? .....

WOMEN ONLY Are you?

Pregnant? Yes ☐ No ☐ DK ☐

Number of weeks: .....

Taking birth control pills or hormonal replacement? Yes ☐ No ☐ DK ☐

Nursing? Yes ☐ No ☐ DK ☐

Allergies. Are you allergic to or have you a reaction to:

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicilin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Other:			

	Yes	No	DK
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired completely in the last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no linger recommended for any other form of CHD.

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐

	Yes	No	DK
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify:_____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders If yes, specify:_____	☐	☐	☐
Recurring infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐

	Yes	No	DK
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
Cardiovascular disease..			
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure.	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve problem	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐

HEALTH HISTORY FORM

MEDICAL INFORMATION CONTINUED

	Yes	No	DK		Yes	No	DK
Abnormal bleeding	☐	☐	☐	Hemophilia	☐	☐	☐
Anemia	☐	☐	☐	AIDS or HIV infection	☐	☐	☐
Blood transfusion	☐	☐	☐	Arthritis	☐	☐	☐

If yes, date.....

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... ☐ ☐ ☐

Name of physician or dentist making recommendation: _____Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... ☐ ☐ ☐

Please explain:

NOTE: Both the doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____

Date: _____

Signature of Dentist: _____

Date: _____

COMMENTS FOR COMPLETION BY DENTIST

_____

_____

_____

_____

_____

Reynoldsburg DENTAL CENTER

PEDIATRIC QUESTIONNAIRE

PLEASE MARK YOUR ANSWERS

1. Does your child have trouble going to bed or falling asleep? _____
2. Awaken during the night and has trouble returning to sleep? _____
3. Does he/she tend to breathe through their mouth during the day or during sleep? _____
4. Dry mouth or bad breath on waking in the morning? _____
5. Have you noticed in your child while sleeping:
    a. Snore or have heavy or loud breathing? _____
    b. Break or pause in breathing? _____
    c. Gasp, choke, or struggle to breathe? _____
    d. Restless or agitated sleep? Grind teeth? _____
    e. Abnormal head postures (hyperextension, etc)? _____
    f. Excessive sweating? _____
    g. Wet the bed? _____
6. Have you noticed in your child during the day:
    a. Difficult to awake? _____
    b. Wakes with headaches? _____
    c. Groggy or tired, "out-of-it"? _____
    d. Hyperactive? _____
    e. Teachers commented? _____
7. Child often:
    a. Does not seem to listen when spoken to directly? _____
    b. Has difficulty organizing tasks? _____
    c. Easily distracted by extraneous stimuli? _____
    d. Fidgets with hands or feet or squirms in seat?
    e. Interrupts or intrudes on others? _____
8. Is your child frequently sick, has a history of sore throat, ear infections, sinus infections, or allergies? _____
9. Stop growing at a normal rate at any time since birth? _____
   Overweight? _____
10. Habits: pacifier /thumb sucking /lip biting / other? _____

Other:

_____

_____

Modified from:
Ronald D. Chervin, MD, MS; Robert A. Weatherly, MD; Susan L. Garetz, MD; Deborah L. Ruzicka, RN, PhD; Bruno J. Giordani, PhD; Elise K. Hodges, PhD; James E Dillon, MD; Kenneth E. Guire, MS Pediatric Sleep Questionnaire Prediction of Sleep Apnea and Outcomes. Arch Otolaryngol Head Neck Surg. 2007;133:216-222

REYNOLDSBURG DENTAL CENTER
Ryan L. Naylor, D.D.S, William J. Lenz, D.D.S, and
John Park, D.D.S
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(614) 866-4186

FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of the estimated patient portion is due at the time of treatment. We strive to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options.

1. Cash, Check, or Visa, Mastercard and Discover.

2. Flexible payment plans pf up to 18 months upon approval with Care Credit®. Approval must be received prior to treatment date.

3. In house payment plans, as determined appropriate on a case-by-case basis.

As a courtesy to you, we will gladly process your insurance claim forms. Our responsibility it to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans may not correspond to individual patient needs, and as such, some routine and necessary dental services may not be covered even though you may need those services.

Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. We understand guidelines can be hard to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company, we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is processed.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

Returned Checks - A fee of $30 will be charged for any returned checks.

Minor patients - The adult accompanying the minor is responsible for the payment on the account at the time of service.

By signing this form I authorize Reynoldsburg Dental Center to process credit card transactions initiated by me either by mail or phone. I have read and fully understand my financial options and obligations.

_____ _____

Signature of Patient and/or Legal Guardian Date

SLEEP EVALUATION / CLINICALS

Patient Name: _____ **Date of Birth:** / /

Gender: M ____ F ____ Height: _____ Weight: _____ Blood Pressure: _____

PLEASE CHECK ANY OF THE FOLLOWING YOU MAY HAVE

- ☐ Morning headaches
- ☐ Frequent urination at night
- ☐ Erectile Dysfunction
- ☐ Atrial Fibrillation
- ☐ Grinding Teeth
- ☐ Heart Disease
- ☐ ADD/ADHD
- ☐ Fibromyalgia
- ☐ Renal Failure
- ☐ Restless Legs (RLS)
- ☐ Stroke
- ☐ Depression
- ☐ Overweight
- ☐ COPD
- ☐ Memory Loss
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Failure
- ☐ GERD
- ☐ Low Testoterone

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS:

1. Do you snore *or* have been told that you snore? ☐ YES ☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime? ☐ YES ☐ NO
3. Has anyone observed you stopped breathing or gasp for air during your sleep? ☐ YES ☐ NO
4. Do you have or are you being treated for high blood pressure? ☐ YES ☐ NO

IF YOU ANSWERED YES TO 2 OR MORE OF THE ABOVE, PLEASE CONTINUE:

EPWORTH SLEEPINESS SCALE

	Never doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting or reading?	☐ 0	☐ 1	☐ 2	☐ 3
2. Do you get sleepy, or doze off, while watching TV?	☐ 0	☐ 1	☐ 2	☐ 3
3. While sitting or inactive in a public place?	☐ 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?	☐ 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 at a traffic light?	☐ 0	☐ 1	☐ 2	☐ 3

Total Score: _____

Have you ever been diagnosed with Sleep Apnea? ☐ YES ☐ NO
Are you currently using CPAP (or any other apnea/snoring device? ☐ YES ☐ NO
Are you currently taking any sleeping aids? (prescribed or OTC)? ☐ YES ☐ NO
Are you currently taking any prescribed pain medication? ☐ YES ☐ NO

UNTREATED SLEEP DISORDERS ARE RELATED TO MANY HEALTH *AND* FINANCIAL COMPLICATIONS:

***Diabetes *Premature death *5X the risk of heart attack *2X the risk of stroke *Weight grain *6X the risk of a serious automobile accident *Increased risk of cancer *Hypertension *Depression *Erectile dysfunction *Daytime fatigue *ADHD *GERD *Decreased job performance *RLS/PLM *Increased cost of healthcare *Chronic/migraine headaches *Post-surgical complications/death *Chronic pain *Weakened immune system *Renal failure *Heart disease**

Provider Signature/Initials* _____

*To be filled for reference and review in patient's chart notes

REYNOLDSBURG DENTAL CENTER

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 acknowledgment of receipt of our Notice of Privacy Practices, 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)

_____

_____