Welcome to your Dental Home!

Date______________

Name: ____ Prefer to be called____________
Mr./ Mrs./ Miss/ Ms./ Dr. Last First Middle

Home Address: ____ Phone: Home____________ Cell____________
(city & zip code) ____ Work:____________________________
Age: ____ Birthdate: _______________ Social Security #:_______________________
Where and when are best times to reach you:____
E-mail_____________________________
Employer: __________________________ How long there? _____ Occupation: ____________________
Employer address: ____

Neighbor or Relative not living with you

Name:____________________________ Relation:________ Work Phone:__________ Home Phone:__________
Address: ____

Name of Spouse ____ Birthdate _______________
Last First Middle
Employer: ____ Work Phone ____________________

Who is legally responsible, if other than patient? ____
Last First Middle
Relationship to patient __________________________________ Phone _________________________
Address ____
Emergency Contact: Name______________________________ Phone #__________________________
Address:____________________________ Cell#____________________________

Whom may we Thank for referring you? ____
Other family members seen by us? ____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name ____________________________________ Phone# _____________
Group # _________________________ Social Security # __________________
Insured's Name _________________________________ Insured's Birthdate _____________ Relation _______
Insured's Employer/Address ____

Secondary Insurance

Insurance Co. Name ____________________________________ Phone# _____________
Group # _________________________ Social Security # __________________
Insured's Name _________________________________ Insured's Birthdate_____________ Relation ________
Insured's Employer/Address ____

We are pleased to welcome you to our practice!

MEDICAL HISTORY

Name: ____ Date_____________
Mr./ Mrs./ Miss/ Ms./ Dr Last First Middle .

Please fill out these forms as completely as you can. The thoroughness of this medical history is designed for your safety, and complete answers will assist us in treating you with consideration for your special needs.
We look forward to assisting you in maintaining good oral health.

Physician ___________________________Specialty____________ Date of last visit ___________
Address ____ Phone ________________

Please circle YES or NO

Y/N Do you have a current medical problem ________________________________
Y/N Are you currently under the care of a physician ___________________________
Y/N Have you been hospitalized or had a serious illness in last 5 years _________________
Please explain ____
Y/N Are you currently taking any medications (please list) ______________________________

Y/N Do you have heart trouble or any form of cardiovascular disease?

- ☐ Angina (chest pains) Frequency ____
- ☐ Heart attack (date) _____________
- ☐ Heart Surgery _________________
  - Pacemaker
  - Bypass
  - Prosthetic heart valve
- ☐ Stroke (date) __________________
- ☐ Rheumatic Fever (date) _____
- ☐ Heart murmur
- ☐ High Blood Pressure
- ☐ Congenital heart lesions
- ☐ Mitral valve prolapse
- ☐ Other

Y/N Do you have diabetes/hypoglycemia?

Y/N Have you ever been diagnosed with sleep apnea/or use a CPAP machine?

Y/N Do you have kidney disease?

Y/N Have you ever had hepatitis? Type A (Food) Type B (Blood)

Y/N Have you ever had liver disease or jaundice? (date) ___________________________

Y/N Have you ever had tuberculosis

Y/N Have you ever suffered trauma to your head or neck, such as in a car accident?

Y/N Have you had surgery, radiation, chemo or other treatment for a tumor or growth?

Y/N Have you received or are you currently receiving medication known as bisphosphonates (ex: zoledronic acid [Zometa], fosamax, or pamidronate [Aredia])?

Y/N Do you or have you had mental health conditions?

Y/N Do you have any problems with excess bleeding? Have you had a blood transfusion? Y / N

Y/N Do you have any blood diseases?

- ☐ Anemia
- ☐ AIDS or HIV
- ☐ Leukemia
- ☐ Venereal Disease
- ☐ Other____________

Y/N Do you have:

- ☐ Stomach/Intestinal Ulcers
- ☐ Emphysema
- ☐ Asthma
- ☐ Coughing
- ☐ Breathing Problems
- ☐ Fainting Spells
- ☐ Convulsions
- ☐ GI Reflux Disorder
- ☐ Epilepsy

Medical History

Y/N Do you have any form of arthritis?

Y/N Have you taken Phen-fen?

Which joints are involved? ____

Have you ever had:

- ☐ Hip/Joint replacement ☐ Organ transplant

Y/N Do you have glaucoma?

For Women Are you:

- ☐ Pregnant (Expected delivery date) _______________
- ☐ Nursing
- ☐ Taking birth control pills
- ☐ Have you reached menopause? If YES, what hormones/herbs are you taking, if any? __________________ ____

Are you allergic to or have you had an unusual reaction to any of the following:

___Penicillin	___Codeine	___Local Anesthetics
___Erythromycin	___Aspirin	___Other:________________
___Sulfa	___Jewelry/Nickel	___Any other drug allergies:______________
___Epinephrine	___Other pain medications	
___Latex	___Other Antibiotics	

Y/N Have you ever been advised not to take a particular medication?

Y/N Have you ever been advised to take prophylactic antibiotics before dental treatment?

Y/N Please indicate if consume the following:

- ☐ Herbal Remedies/Vitamins
- ☐ Alcohol: (______) drinks per day/week. In prior years: same / more / less
- ☐ Tobacco/pipe/chew: (______) packs per day for approximately (______) years
- ☐ Soda/Canned/Bottled beverages (_____) per day / week
- ☐ Acidic/Sour Candy/Cough Drops/Breath Mints (_____) per day / week
- ☐ "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have fatal interaction with local anesthetics or common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor. ____

Do you play sports? If so please list: ____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____ _________________________

Signature Date

DENTAL HISTORY

Name: ____ Date____________________
Mr./ Mrs./ Miss/ Ms./ Dr Last First Middle

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs.

When was your last?

- ☐ Dental visit: ___________________________________
- ☐ Full mouth x-rays: ______________________________
- ☐ Complete dental exam: __________________________

Why have you come to the dentist today? ____

Is any part of your mouth sensitive to the following?

Hot Cold Pressure Other:_____________

Please circle YES or NO

Y/N Do your gums bleed when you brush your teeth?

Y/N Does food catch between your teeth?

Have you ever:

- Y/N Had orthodontic care
- Y/N Had any teeth removed/Are you interested in implants Y/N
  - If yes, why? ____
- Y/N Been informed that you have gum problems
  - If yes, when? _______________________ By Whom __________________
- Y/N Had periodontal treatment or gum surgery
  - If yes, when? _______________________ By Whom __________________
- Y/N Been told you grind your teeth while sleeping or clench during the day
  - If yes, how often? ____

Please indicate which items you use and note **how often**:

- ☐ Hard-bristle toothbrush
- ☐ Soft-bristle toothbrush
- ☐ Electric toothbrush
- ☐ Proxi-brush
- ☐ Rubber tip
- ☐ Dental floss
- ☐ Water spray
- ☐ Stimudents or toothpicks
- ☐ Other _______________

Do you have?

- Y/N Dryness in your mouth
- Y/N Bad taste or odor in your mouth
- Y/N Burning sensations in your mouth
- Y/N Stiff, painful or tired jaw muscles
- Y/N Loose teeth
- Y/N Frequent cold sores, canker sores, or fever blisters on your gums, cheeks or lips
  - If YES, how often and where? ____
- Y/N Growths or swellings in your mouth
  - If YES, where are they located and how long have they existed? _________________
- Y/N Jaw clicking, popping or making grating-like noises
  - If YES, when? ____
- Y/N Chronic headaches or neck aches
- Y/N Pain or soreness around your eyes, ears or other parts of your face
- Y/N Anxiety about dental treatment

Dental History

Do you:

- Y/N Have implants
- Y/N Wear removable denture, partial or protective nightguard
  - If YES, when do you wear it? ____
- Y/N Want to learn to control your dental disease to preserve your teeth and oral health
-
- Y/N Have any disease or condition which was not addressed above that you feel is important for us to know
  - If YES, please explain ____

Y/N **Are you happy with the way your smile looks?**
If No, please explain (whiter teeth, straighter teeth, fresher breath, etc.) ____________________
____

Reasons for seeking a new Dentist____
Have you experienced serious problems with previous dental work ______________________________
What do you like most/least about visiting the Dentist?______________________________

Previous Dentist ______________________________ Specialty ____________________
Period of Treatment ______________________________ Date of Last Visit ____________________
Address ____
Number Street City State ZIP (Area Code) Phone

Other Dentist ______________________________ Specialty ____________________
Period of Treatment ______________________________ Date of Last Visit ____________________
Address ____
Number Street City State ZIP (Area Code) Phone

I have received a copy of this office's
NOTICE OF PRIVACY PRACTICES

Print Name **Signature** **Date**

---------------------FOR WRITTEN OFFICE USE ONLY---------------------
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign *Communication barrier prohibited obtaining the acknowledgement*
An emergency situation prevented us from obtaining acknowledgement *Other (please specify):* ____________________

I acknowledge that I have received a copy of the Dental Materials Facts sheet dated May 2004

Patient Signature **Date**

Sleep Disorder Breathing Questionnaire

Patient Name: ___________________________ Age: _____ Date: ____________

- **OVER A MILLION AMERICANS SUFFER FROM SLEEP APNEA.**
- **PEOPLE WITH SLEEP APNEA ARE 3 TIMES MORE LIKELY TO BE INVOLVED IN MOTOR VEHICLE ACCIDENTS**
- **90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED.**

Do you snore?	**Yes**	**No**
Do you have high blood pressure?	**Yes**	**No**
Have you gained weight and find it difficult to lose?	**Yes**	**No**
Do you have unexplained awakenings from sleep?	**Yes**	**No**
Do you awaken from sleep gasping for air or choking?	**Yes**	**No**
Do you notice frequent twitching of jerking of legs while asleep?	**Yes**	**No**
Do you lack energy upon waking in the morning?	**Yes**	**No**
Do you have a headache upon waking in the morning?	**Yes**	**No**
Do you often lay in bed unable to fall asleep?	**Yes**	**No**
Do you wake up during the night and are unable to fall back asleep?	**Yes**	**No**
Do you find it difficult to stay awake during the day?	**Yes**	**No**

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0= would never doze
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

Sitting and reading	__________
Watching TV	__________
Sitting inactive in a public place	__________
As a passenger in a car for an hour without a break	__________
Lying down to rest in the afternoon	__________
Sitting and talking to someone	__________
Sitting quietly after lunch without alcohol	__________
In a car, while stopped for a few minutes in traffic	__________
Total Score	__________

If your Epworth Sleepiness score is 10 or greater please consult with your dentist/doctor

Total Wellness Screening

At Laurene K. Duke Total Wellness Dentistry we are devoted to helping you establish your teeth and bite system in optimal health, for a lifetime. We are equally committed to your whole body health

Please circle the answer that best describes you:

- Do you have a family history of heart disease or strokes: Yes No
- Do you have a family history of Type II Diabetes: Yes No

Periodontal Pathogens (harmful oral bacteria)
Studies show that harmful bacteria in the mouth are a primary cause of tooth decay, bleeding gums, periodontal disease, tooth loss and body-wide inflammation.

- Have either of your parents, or siblings, lost their teeth or have been diagnosed with periodontal disease? Yes No
- Do your gums bleed easily? Yes No

Nutrition
Studies show that whole fruits and vegetables strengthen bone, gums and teeth.

- Approximately how servings (cups) do you eat each day? 0-2 3-4 >4 servings

Studies show that physical activity is critical to total wellness and that physical inactivity is "the biggest public health issue of the 21st century".

How physically active are you?

1. I'm very physically active – I purposefully exercise several times every week.
2. I'm pretty physically active- I try to exercise when I can.
3. I'm not very physically active – I wish I were!

Toxins Exposure
Studies show that toxins, such a tobacco and mercury overexposure (fish), are significant risk factors for body-wide inflammation.

- Do you smoke or chew tobacco? Yes No
- Do you eat largemouth fish (bass, tuna, grouper, etc.) more than once a week? Yes No

MISSED APPOINTMENT POLICY

Definitions:

POLICY- *a way of managing affairs so as to achieve some purpose*
APPOINTMENT- *a meeting with someone at a certain time and place*
MISSED- *fails to keep, do or be present at.*

It is our wish that each and every one of our patients receive the very best care and service possible. Your treatment program consists of a specific series of appointments given over a pre-planned time span. It is important to follow through with these visits to get the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and be indicative that we did not care. And that is not what we stand for.

Therefore, in order to work together we want to review a set of agreements that will be followed throughout the course of your visits to our office:

1. Arrange the activities in your life so that you can meet all your appointments. We know how busy life can be, but make this a priority!
2. If you are unable to make it to the appointment, we kindly ask that you give us at least a 48hour notice. This courtesy allows us help another patient in your place.
3. Failure to notify us will result in a **$50.00 missed appointment** charge for each hour reserved for you.

We look forward to helping you and value your trust. Thanks again for allowing us to serve you!

Patient________________________________ **Doctor:** *Laurene K. Duke, D.D.S*

Signature of Patient______________________ **Date**____________________________

--- MUST BE SIGNED BEFORE ANY FUTURE APPOINTMENTS CAN BE MADE ---

Our Financial Policy

We require payment at the time services are rendered in our office.

We realize every person's financial situation is different. Therefore, we provide several different payment options to our patients.

Cash or Check:

Total payment of the fee paid by *check* or *cash* at each visit.

- A $10 fee will be applied for any returned checks
- As a courtesy to our patients who pay in full at time of service we extend a 5% courtesy on all preventative and diagnostic treatment (i.e. Exams, x-rays and routine hygiene maintenance). Due to an increase in product and lab costs we are no longer able to extend the courtesy of restorative services. By doing this we have been able to provide the same level of care without raising our base costs to our patients.

Credit Card

The fee may be paid with *Visa, Mastercard* or *Discover*.

- The 5% reduction for cash payment is ***not*** applicable under this plan.

Layaway Payments

Make regular payments prior to the treatment being completed. Once a credit is built up we will start treatment.

Care Credit or Citi Bank

Dr. Duke pays the interest for 6 months so you have a convenient, low minimum monthly payment. Apply here in our office or in the convenience of your own home via the internet.

Insurance:

An insurance card or completed and signed insurance form must be provided by the patient at the first appointment. As a courtesy to our patients, we will gladly submit your insurance claim. However, we cannot guarantee any estimated coverage, since the insurance policy is an agreement between you and your insurance carrier.

All patients are expected to pay their estimated portion of the cost of service at the time services are rendered. In some instances, your insurance may pay more or less than the estimate given. In these situations, we will notify the patient with a statement if there is a balance, or issue a refund check, if the insurance pays more than the estimate.

Insurance Authorization (must be signed if insurance is to be billed)
I certify that I am covered by ______________________________ Insurance Co. and I assign directly to Dr. Duke all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I authorize the dental staff to perform the necessary dental services I may need and to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. ____ Signature

I have read and understand the financial policy.

____

Signature

Relationship to Patient (check):

self guarantor parent/guardian

Patient Photo/Videos Release Form

I, the undersigned patient, hereby authorize Laurene K. Duke D.D.S. APDC or any of their assignees to take photograph, videos, or slides of my face, jaws and teeth.

I understand that the photographs/videos or slides will be used as a record of my dental care and may also be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television and professional publications (dental magazines and journals).

I further understand that if the photographs/videos or slides are used in any publication, my name or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please Initial:

_______ I do not mind if my name and face are used in any of the above stated situations.

_______ I do not wish to have my name released.   _______ I do not wish to have my face shown.

Patient Disclosure Instructions

In general, the HIPPA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

ELECTRONIC TEXT AND EMAIL APPOINTMENT REMINDERS

We know that our patients lead busy lives. Because of this we have an automated system that. With these texts and email our patients are able to confirm or reschedule their appointments if needed.

If you would prefer to not receive one or both of these you can Opt-Out once the first message is received.

I wish to be contacted in the following manner (check all that apply):

Telephone *(Specify Home, Cell, and/or Work for chosen option):*

____Ok to leave message with detailed information **HOME   CELL   WORK**

____Leave message with appointment time & date and/or call back number only **HOME   CELL   WORK**

Electronic Communications:

____OK to email appointment time/date information

____OK to email treatment details

____OK to fax to number indicated

Written Communication:

____OK to mail to my home address

____OK to mail to my work/office address
(If so please verify we have work/office address)

I allow you to give my clinical information to or answer questions from (check all that apply):

____Spouse   ____Child   ____Other (specify):

____Parent   ____None

____   ___________________

Patient Signature   Date

____   ___________________

Printed Name   Birth Date