PATIENT REGISTRATION

Bach Sleep Center

"Giving You Something To Smile About"!

YOUR INFORMATION

First Name: ____ MI ___ Last Name: ____

Birthdate: __________________SSN: _____________ Sex: _____ Email: ____

Please Check One: ____Single ____Married ____Separated ____Divorced ____Widow Full Time Student: ___Y ___N

Address: ____ City: _______________________ State: _____ Zip: _______________

Home Phone: _________________________ Cell Phone: _________________________ Work Phone: _________________________

INSURANCE

Primary Dental Coverage

Policy Holder's Name: ______________________________

Relationship to Patient: _____________________________

Policy Holder's DOB: _______________________________

Policy Holder's SSN: _______________________________

Policy Holder's Employer: ___________________________

Secondary Dental Coverage

Policy Holder's Name: ______________________________

Relationship to Patient: _____________________________

Policy Holder's DOB: _______________________________

Policy Holder's SSN: _______________________________

Policy Holder's Employer: ___________________________

COORDINATION OF CARE

To serve you best, please provide the following contact information:

Primary Care Physician: __________________________________ Sleep Doctor: ____________________________________

Previous Dentist: _____________________________________ Other Specialist: ____________________________________

Emergency Contact: ___________________________ Relationship: _______________________ Phone: _______________

Medical Power of Attorney: ____ (Please provide documentation)

COMMUNICATION

❖ Our office will help remind you and your family of upcoming appointments via Telephone or Email/Text. It is critical that we receive confirmation from you regarding your visit. Additionally, should rescheduling be necessary, kindly give our office THREE business days' notice. Once you opt into a confirmation method preference, please note that responding will prompt our systems that further attempts to reach you are not necessary. _____Telephone _____Email/Text

❖ May we contact you via your provided home and cell phone numbers regarding financial questions and information? ____Yes _____No

❖ How did you hear about our office?

___Mailed Offer ___Newspaper ___Radio ___Walk-In ___Website ___Facebook ___Phone Book ___Billboard

___Personal Referral (Name: _________________________) ___ Special Event (_____________________________)

PATIENT REGISTRATION

Missed Appointment Policy

Please help us to serve you and all our patients by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us THREE business days' notice. _____(Initial)

Insurance & Financial Policies

- In most cases, we are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your claim and help you maximize your benefits. We will provide an estimated coinsurance payment for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage or lack of. You are responsible for knowing your own benefit details. ______(Initial)

- I hereby authorize my insurance company to assign benefits directly to the office of Watertown Dental Care, PLLC. I understand that I am responsible for all costs of dental treatment. I authorize Watertown Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the information I have provided on this Patient Registration form and the Medical and Dental Histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information to third party payors and/or other health professionals. I also authorize the use of my signature below on all insurance submissions. _____(Initial)

- In order to make financial arrangements for your treatment, we offer several flexible options. We accept cash, checks, most major credit cards, Care Credit as well as short-term payment plans in the event of a denial for financing. By signing below, you understand and agree that you are financially responsible for all charges associated with this account.

______________________	______________________	______________________
Print Name	Signature	Date

Summary Notice of Privacy Practices

Watertown Dental Care keeps information of all our dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice.

You have a right to a copy of this "Notice" Please check your option below:

___I am requesting a copy of Watertown Dental Care's "Summary Notice of Privacy Practices".

___ I do not wish to receive a copy of the Watertown Dental Care's "Summary Notice of Privacy Practices" at this time. I reserve the right to request a copy at a later date.

I have had a full opportunity to read and consider the contents of this office's "Summary Notice of Privacy Practices". I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

______________________	______________________	______________________
Print Name	Signature	Date

Medicare

Are you covered by Medicare? _____No _____Yes

If Yes, please see our office personnel for important information regarding your coverage. Thank You

Additional Items

Please provide us with a copy of a photo ID and your dental insurance card. We will utilize these items to verify and protect your identity.

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury ______
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ________)
   - latex
   - nuts ______
   - fruit ______
   - other ______
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis ______
5. artificial heart valve, repaired heart defect (PFO) ______
6. pacemaker or implantable defibrillator ______
7. orthopedic implant (joint replacement) ______
8. rheumatic or scarlet fever ______
9. high or low blood pressure ______
10. a stroke (taking blood thinners) ______
11. anemia or other blood disorder ______
12. prolonged bleeding due to a slight cut (INR > 3.5) ______
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. tuberculosis, measles, chicken pox ______
15. asthma ______
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ______
18. liver disease ______
19. jaundice ______
20. thyroid, parathyroid disease, or calcium deficiency ______
21. hormone deficiency ______
22. high cholesterol or taking statin drugs ______
23. diabetes (HbA1c = ______) ______
24. stomach or duodenal ulcer ______
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis ______
28. autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______
30. contact lenses ______
31. head or neck injuries ______
32. epilepsy, convulsions (seizures) ______
33. neurologic disorders (ADD/ADHD, prion disease) ______
34. viral infections and cold sores ______
35. any lumps or swelling in the mouth ______
36. hives, skin rash, hay fever ______
37. STI/STD/HPV ______
38. hepatitis (type ___) ______
39. HIV/AIDS ______
40. tumor, abnormal growth ______
41. radiation therapy ______
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ______
44. psychiatric treatment ______
45. antidepressant medication ______
46. alcohol/recreational drug use ______

ARE YOU:

47. presently being treated for any other illness ______
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______
49. taking medication for weight management ______
50. taking dietary supplements ______
51. often exhausted or fatigued ______
52. experiencing frequent headaches ______
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person ______
55. often unhappy or depressed ______
56. taking birth control pills ______
57. currently pregnant ______
58. diagnosed with a prostate disorder ______

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ________

Doctor's Signature ______________________ Date ________

ASA ______ (1-6)

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DENTAL HISTORY

Name ________________________________ Nickname ______________________________ Age ___________
Referred by ___________________________ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _______________________________ How long have you been a patient? _______________ Months/Years
Date of most recent dental exam ______ /______ /______ Date of most recent x-rays _______ /_______ / ______
Date of most recent treatment (other than a cleaning) ______ / ______ / ______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ______________________
2. Have you had an unfavorable dental experience? ______________________
3. Have you ever had complications from past dental treatment? ______________________
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ______________________
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ______________

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______________________
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________________
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______________________
10. Is there anyone with a history of periodontal disease in your family? ______________________
11. Have you ever experienced gum recession? ______________________
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______________________

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ______________________
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______________________
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______________________
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ______________________
18. Do you have grooves or notches on your teeth near the gum line? ______________________
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______________________
20. Do you frequently get food caught between any teeth? ______________________

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________________
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ______________________
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______________________
25. Are your teeth becoming more crooked, crowded, or overlapped? ______________________
26. Are your teeth developing spaces or becoming more loose? ______________________
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______________________
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______________________
30. Do you clench or grind your teeth together in the daytime or make them sore? ______________________
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___
32. Do you wear or have you ever worn a bite appliance? ______________________

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ______________________
34. Have you ever whitened (bleached) your teeth? ______________________
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______________________
36. Have you been disappointed with the appearance of previous dental work? ______________________

Patient's Signature ____ Date ______________
Doctor's Signature ____ Date ______________

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Sleep Health Questionnaire

☐ M ☐ F

Name | Gender | DOB

Address, City, State, Zip | Weight | Height

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Question	Y or N	Points
Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score		

Risk Level	**Low**	**Moderate**	**High**	**Severe**
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

- ☐ Hypertension
- ☐ Snoring
- ☐ Diabetes
- ☐ Depression
- ☐ Grind Teeth
- ☐ Acid Reflux
- ☐ Stroke/Heart Disease
- ☐ Unrefreshed Sleep
- ☐ Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder?	☐ Yes	☐ No
Are you currently using a CPAP machine?	☐ Yes	☐ No
Do you use your CPAP less than 5 times a week?	☐ Yes	☐ No
Would you prefer an oral appliance?	☐ Yes	☐ No

Please Present Completed Form, ID & Medical Insurance Card to Front Desk to Allow for Copies

Fax: 888-999-1887 Email: orderentry@ezsleeptest.com Phone: 888-240-7735

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