The Offices Of
Bernard Lynch, DMD, FAGD

DENTALCARE BURKE
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McLean, VA 22102
(703) 790-5533

ALEXANDRIA ART OF DENTISTRY
624 N. Washington St.
Alexandria, VA 22314
(703) 299-9899

NEW PATIENT INFORMATION

Patient Name: ______________________ Date: __________

1. What specifically happened that prompted you to call Dr. Lynch? ______________________

2. What are your expectations for today's appointment? ______________________

3. If you have a dental problem, what is the one thing you hate most about it? ______________________

4. What would you like to hear during your consultation visit with Dr. Lynch? ______________________

5. When do you want to start your care? ______________________

6. What is the most important improvement you'd like to see once your dental treatment with Dr. Lynch is complete?

7. What do you feel is your main dental problem? What do you feel is wrong? How long have you suffered?

8. Rate how much your dental problem affects you in each of the following areas:
   (*1 = no affect - 10 = affects me very much*)
   Pain: ____ Embarrassment: ____ Eating difficulty: ____ Willingness to Smile: ____

9. Please list everything you've done to try to handle the problem that hasn't worked:

10. Why do you feel that right now is the time to fix your dental problems? ______________________

11. How are your dental problems affecting your everyday life? ______________________

12. Please tell us about any past dental experiences that were upsetting to you? ______

______

13. Have you ever had orthodontic treatment? ______

______

14. What Improvements would you make in the appearance of your teeth? And why? ______

______

15. So let's say we find something. Do you prefer to save your teeth? ______

______

16. Is there anything that would stand in your way of getting the proper dentistry you need? ______
(For example health, work, school, finances, etc)

______

17. Do you have any questions for me?

______

______

MEDICAL HISTORY INFORMATION

Name: **Date:**

Reason for this Visit: **Date of Last Dental Visit:**

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

- ☐ AIDS/HIV
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Back or Neck Problems
- ☐ Bleeding Problems
- ☐ Cancer/Tumors
- ☐ Chest Pain
- ☐ Chemotherapy
- ☐ Chronic Headaches
- ☐ Diabetes
  Type I ___ Type II ___
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Head injuries
- ☐ Heart disease
- ☐ Heart murmur/MVP
- ☐ Hepatitis A, B, C
- ☐ High/Low Blood Pressure
- ☐ Jaundice
- ☐ Jaw Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Mental Disorders
- ☐ Neck Problems
- ☐ Nervous Disorders
- ☐ Oral Herpes
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due Date:________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Sinus problems
- ☐ Stomach Problems
- ☐ Stroke/Heart Attack
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Sexually Transmitted Disease (STDs)

ALLERGIES

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Aspirin Allergy
- ☐ Tetracycline Allergy
- ☐ Latex Allergy
- ☐ Environmental Allergies
- ☐ Other Allergies:

- ☐ Other Conditions Not Listed:

Are you in general good health at this time? ☐ Yes ☐ No *If yes, please rate from 1(best) -10 (worst):*

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:

Do you use tobacco? ☐ Yes ☐ No

How much? How long? Type?

Have you ever had an allergic reaction to Novocaine anesthetic? ☐ Yes ☐ No

If yes, any reactions or allergic symptoms, please explain:

Do you have a history of Periodontal (gum) Disease? ☐ Yes ☐ No

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

Are you taking medication? ☐ Yes ☐ No *If Yes, Please list all (including Herbs, Vitamins, Aspirin, prescriptions)*

Name of Physician: Phone:

Please explain if you have any health problems that need further clarification?

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

Payment for dental treatment is due at the time service is rendered. In addition to cash and checks, we accept most major credit cards and third party financing. We reserve the right to send to collections any delinquent account and additional fees will apply. Missed or no-show appointments may be billed up to $550/hour. Credit card refunds will incur a $25 fee and a 5% processing fee.

Signature of Patient and/or Legal Guardian

CONTACT INFORMATION

Patient Name: ______ Date: ______

Last *First* *MI*

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Child ☐ Other: ______

Address: ______

Street *City* *State* *Zip Code*

Social Security #: ______ Birth Date: ______ DL#: ______ Issue date: ______

Home Phone: ( ) ______ Work Phone: ( ) ______ Cell Phone: ( ) ______

E-mail: ______ May we contact you by email? ☐ Yes ☐ No

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Brochure ☐ Dental Office

☐ Previous Practice ☐ Website ☐ Other ______

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

EMPLOYMENT INFORMATION

The Following Is For: ☐ Patient ☐ Person Responsible For Payment

Employer Name: ______ Occupation: ______

Address: ______

Street *City* *State* *Zip Code*

INSURANCE INFORMATION

Name of Insured: ______ Is insured a patient? ☐ Yes ☐ No

Last *First* *MI*

Insured's Birth Date: ______ ID #: ______ Group #: ______ Social Security #: ______

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: ______

If you have dental insurance, we will help you receive the maximum benefits from your policy. As a courtesy to you, we will complete a claim form and send it to your insurance company. You can be reimbursed by your insurance company to your home or have the reimbursement received at the office for future treatment credit.

CONSENT FOR SERVICES

Payment for dental treatment is due at the time service is scheduled. In addition to cash and checks, we accept most major credit cards and third party financing. We reserve the right to send to collections any delinquent account and additional fees will apply. Missed or no-show appointments may be billed up to $550/hour. Credit card refunds will incur a $25 fee and a 5% processing fee.

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.

______ ______

Signature of Patient and/or Legal Guardian *Date:*

ADULT SLEEP & BREATHING QUESTIONNAIRE

Patient Name: ____________________ Date: __________

Last *First* *MI*

☐ Male ☐ Female Date of Birth: __________ Age: ______

Have you ever had a sleep test administered? ☐ Yes ☐ No

If yes - when did you have your last sleep test?

Have you been diagnosed with Sleep Apnea? ☐ Yes ☐ No

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? ☐ Yes ☐ No

Are you happy with your CPAP or Sleep Appliance? ☐ Yes ☐ No

If you are not happy - why?

How often do you get out of bed to use the restroom during the night?

	Yes	*No*
Do you usually wake feeling tired and unrested?		
Do you habitually snore?		
Have you been diagnosed with Hypertension/High Blood Pressure?		
Do you often suffer from waking headaches?		
Do you regularly experience daytime drowsiness or fatigue?		
Do you have blocked nasal passages?		
Has anyone observed you stop breathing during your sleep?		
Do you ever wake up choking or gasping?		
Do you grind your teeth while sleeping?		
Is your neck circumference greater than 40 cm/ 15.75” ?		
Is your Body Mass Index (BMI) more than 35?		

What is your current height?

What is your current weight?

BMI Formula
Your Weight (LBS) x 703 ÷ Your Height (Inches^2)

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EPWORTH SLEEPINESS SCALE

Name: DOB: Date:

This questionnaire was developed to determine the level of daytime sleepiness in individuals It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness.

Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

0 Would *never* doze

1 *Slight* chance of dozing

2 *Moderate* chance of dozing

3 *High* chance of dozing

Chance of Dozing				
0	1	2	3	Sitting and reading
0	1	2	3	Watching television
0	1	2	3	Sitting inactive in a public place (eg, a theater or a meeting)
0	1	2	3	As a passenger in a car for an hour without a break
0	1	2	3	Lying down to rest in the afternoon when circumstances permit
0	1	2	3	Sitting and talking to someone
0	1	2	3	Sitting quietly after a lunch without alcohol
0	1	2	3	In a car, while stopped for a few minutes in traffic

Total Score: ___________

Interpreting Epworth Sleepiness Scale Scores[1,2]

Normal	EDS*	High Levels of EDS*
0-10	>10	>16

Sources: 1. Johns M, Hocking B. Excessive daytime sleepiness: daytime sleepiness and sleep habits of Australian workers. Sleep. 1997;20(10):844-849. 2. Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991;14(6): 540-545. This copyrighted material is used with permission granted by the Associated Professional Sleep Societies—April 2018. Unauthorized copying, printing, or distribution of this material is strictly prohibited.

*Excessive daytime sleepiness.