PATIENT MEDICAL HISTORY

Patient Name (print): _____ Patient Birthdate:_____

Physician Information:

Do you have a Primary Care Physician? ☐ Yes ☐ No
Physician's full name: _____ City, State: _____
When was your last wellness (annual exam) visit? _____
Height _____ Weight _____ (helpful for determining Body Mass Index (BMI) which relates to risk of disease)

Hospitalizations: Please list all hospitalizations, reason and approximate dates.

- _____
- _____
- _____
- _____

Medications: Please list all medications, dosages and reason for taking.

- _____
- _____
- _____
- _____
- _____
- _____

Are you taking an oral biphosphate (i.e, Fosamax, Actonel, Didronel, Boniva, Bonefros)? ☐ Yes ☐ No

Drug Allergies: Please list any drug allergies or sensitivities: _____
_____

Consumption Practices:

Have you or do you use any of the following? ☐ Yes ☐ No If yes, check all that apply:
☐ Cigarettes ☐ Chewing Tobacco ☐ Marijuana ☐ Vapor/E-cig ☐ Hookah
How much do you, or did you, use in one day (i.e, one pack, ½ can): _____ If you quit, what year? _____
Have you tried quitting? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
If so, how much and how often?: _____

Women:

Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No Are you on Hormone Therapy? ☐ Yes ☐ No

Medical Conditions: Check any condition that have OR have had in the past.

☐ Heart Condition	☐ Diabetes	☐ Gastro-esophogeal Reflux	☐ Chemical Dependency
☐ Heart Surgery	☐ High Blood Pressure	☐ Hemophilia	☐ Psychiatric Treatment
☐ Heart Disease	☐ Hepatitis	☐ Bleeding Disorder	☐ Depression/Anxiety
☐ Heart Attack	☐ Kidney Disease	☐ Thyroid Disease	☐ Seizures/Epilepsy
☐ Stroke	☐ HIV/AIDS	☐ Rheumatic Fever	☐ Neurological Problems
☐ Angina	☐ Arthritis/Gout	☐ Scarlet Fever	☐ Fluctuating Weight
☐ Pacemaker	☐ Asthma	☐ Cold Sores	☐ Sleep Apnea
☐ Heart Murmur	☐ Emphysema	☐ Ulcer	☐ Cancer
☐ Osteoporosis	☐ Tuberculosis	☐ Artificial Joint/Limb/Device	☐ Radiation Therapy/Chemotherapy

Is there anything else you would like to discuss with us? _____
_____

Patient Signature: _____ Today's Date: _____
If patient is a minor, Parent/Guardian Name (print): _____
Parent/Guardian Signature: _____ Today's Date:_____

PATIENT DENTAL HISTORY

Patient Name (print): _____ Patient Birthdate:_____

What is your primary reason for seeking dental care? _____

When was the approximate date of your last dental visit and what was it for? _____

_____

Have you ever had a negative dental experience or discomfort that has kept you from seeking care? ☐ Yes ☐ No
If yes, please explain:_____

_____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No
If no, why: _____

Home Care:

How often do you brush your teeth? _____ Check Type: ☐ Manual ☐ Electric Brand: _____
How often do you floss your teeth? _____
Do you floss under your retainer(s) or bridge(s)? ☐ Yes ☐ No ☐ N/A
How often do you brush your tongue? _____
Are you rinsing your mouth? _____ If so, what do you use and how often? _____
Do you use any other special dental aids or tools? If so, please list: _____
Has a prescription toothpaste been recommended by a dentist? ☐ Yes ☐ No
If yes, why: _____
Have you ever whitened or bleached your teeth? ☐ Yes ☐ No If yes, what was the method? _____

General History:

Have you had orthodontic treatment (braces)? ☐ Yes ☐ No
If so, approximately when was treatment completed? _____
Do you wear an orthodontic retainer? ☐ Yes ☐ No Type: ☐ Removable plastic ☐ Cemented bar on teeth
If so, specify how often you wear it: _____
Have you had your third molars (wisdom teeth) removed? ☐ Yes ☐ No If so, when? _____

Do your gums feel tender and/or bleed easily? ☐ Yes ☐ No
If so, how often and when? _____
Have you had periodontal (gum) treatment or surgery? ☐ Yes ☐ No If so, approximate date: _____
Have you had deep scaling (root planning)? ☐ Yes ☐ No If so, approximate date: _____

Do you have any clicking or popping in your jaw joints? ☐ Yes ☐ No
If so, how long has this been present? _____
Do you have pain in your jaw joints? ☐ Yes ☐ No
Do you wear a biteguard? ☐ Yes ☐ No
If so, specify an upper or lower and how often is it worn: _____
Do you wear a sleep appliance? ☐ Yes ☐ No
If so, specify how long you've worn it and how often: _____
Are you aware OR have you been told that you grind or clench your teeth? ☐ Yes ☐ No
Do you get headaches? ☐ Yes ☐ No

Do you gag easily during your dental visits? ☐ Yes ☐ No If so, when?_____
Do you notice that your mouth is dry? ☐ Yes ☐ No If so, when?_____
Do you have problems with teeth or fillings breaking? ☐ Yes ☐ No
Are your teeth sensitive to the following?: ☐ hot temperature ☐ cold temperature ☐ pressure ☐ sweets
Where is your sensitivity located? _____

Is there anything else that you would like us to know about your dental history? _____

_____

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____
Preferred Name: _____

How did you hear about our studio practice? _____
_____

Social Security Number: _____

Home Address: _____
City, State, Zip: _____
Email Address: _____
Home Phone Number: _____
Cell Phone Number: _____
Work Phone Number: _____
Contact Preference: ☐ Email ☐ Home ☐ Cell ☐ Work

Employer Name: _____
Employer Address: _____
Occupation: _____

Emergency Contact: _____
Relation: _____
Phone: _____

Primary Dental Insurance: _____
Insurance City, State: _____ Insurance Phone: _____
Policy/Member ID: _____ Group Number: _____
Policy Holder's Information:
Name: _____
Social Security Number: _____ Birthdate: _____

Secondary Dental Insurance (if applicable): _____
Insurance City, State: _____ Insurance Phone: _____
Policy/Member ID: _____ Group Number: _____
Policy Holder's Information:
Name: _____
Social Security Number: _____ Birthdate: _____

RECORDS RELEASE

If you would like us to request x-rays from your previous dentist, please fill out this form:

Previous Dentist Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

Please send the following information as digital images via email:

- Most recent full mouth series
- Most recent panoramic radiograph
- Most recent bitewings and periapicals
- Most recent periodontal charting
- Other: _____

I authorize my dental records to be forwarded to Brooks Dental Studio.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

If minor, Parent/Guardian Signature: _____

Please send to: Brooks Dental Studio
info@brooksdentalstudio.com

To contact us: 253.777.0600

A Notice of Privacy Practice for Brooks Dental Studio

This notice about our privacy practices is being provided to you in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is required by law because we "conduct certain transactions in electronic form", such as submitting your dental insurance claims electronically. The intent of HIPPA is to protect individually identifiable health information from being misused.

As your provider of dental care, we collect and maintain the information contained in your dental records. These records include information pertinent to facilitating your dental care and running our practice. We are required to notify you that we disclose your information for the purpose of treatment, payment and for health care operations.

1. **Treatment** means providing, coordinating and/or managing health care related services by one or more health care providers or technicians. For example, we may need to share information with other providers and specialists involved in the continuation of your care.
2. **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental insurance plan for your dental services.
3. **Health Care Operations** pertain to all aspects of maintaining and running our practice. For example, patient information may be used for training, or quality assessment purposes.

Unless you request to otherwise, we may use or disclose health information to a family member, friend or other personal representative to assist with your healthcare or to receive payment for you dental services. We make every effort to attend to your specific situation conscientiously. In addition, we may use your confidential information to remind you of an appointment by sending reminder postcards and/or leaving messages at home and/or work.

HIPAA identified certain rights regarding the use of your protected health information. If you feel your privacy rights have been violated, you may file a written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights. Your rights include:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The rights to access, inspect, and copy your protected health information.
4. The right to receive an accounting of disclosures of protected health information outside of treatment, payment, and health care operations.
5. The right to obtain a paper copy of this notice upon request.

For more information about HIPAA or to file a complaint please contact:
Department of Health and Human Services Office of Civil Rights- Toll Free Number: 877-696-6775

Payment & Records Release Practices for Brooks Dental Studio

I authorize Brooks Dental Studio to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company pay directly to Brooks Dental Studio.

I understand that my dental insurance may pay less than the actual bill for service and I will be responsible to pay the balance. In the case of non-covered procedures, including Delta Dental plans, fees are the full responsibility of the patient. I acknowledge this privacy notice and accept responsibility and agree to be obligated to pay the office in accordance with its payment policies.

Signature: _____ Date: _____

Please note that you are being informed of our Privacy and Payment & Records Release Practices.

We value your trust in our office and welcome any questions or concerns you may have.

Brooks Dental Studio 732 Broadway Suite 101 Tacoma WA 98402

This notice is updated as of April 2014

Patient Name: _____ Today's Date: _____ Birthdate: _____

Airway Screening

Epworth Sleep 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 and circle the most appropriate number for each situation.

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (i.e, theater or meeting)	0	1	2	3
4. As a passenger in a car less than an hour	0	1	2	3
5. Lying down in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch with alcohol	0	1	2	3
8. In a car while stopped for a few minutes in traffic	0	1	2	3

Sleep Observations:

1. Do you Snore?	Yes	No	Unsure
a. Do you snore loud enough to be heard through closed doors?	Yes	No	Unsure
b. Do you wake your sleep partner at night?	Yes	No	Unsure
2. Do you often feel tired or fatigued after sleep?	Yes	No	Unsure
3. Has anyone observed that you quit breathing while sleeping?	Yes	No	Unsure
4. Do you take medication for high blood pressure?	Yes	No	Unsure

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History:

1. Has anyone in your family been diagnosed with sleep apnea?	Yes	No	Unsure
If so, who and what is their treatment? _____			
2. Has any Primary Care Physician ever discussed sleep apnea with you?	Yes	No	Unsure
3. How do you prefer to sleep? *Circle all that apply:*	Back	Side	Stomach
4. Have you had fluctuating weight loss or gain of 10lbs or more in the last year?	Yes	No	Unsure
5. Have you been frustrated with attempts at weight loss or weight gain?	Yes	No	

If you have been tested for sleep apnea, please answer the following:

1. Have you ever had a sleep study performed?	Yes	No
2. Are you currently being treated for sleep apnea?	Yes	No

If so, what is the treatment? _____

*How often are you using the recommended treatment?*_____

3. Are you looking for a different way to treat your sleep apnea?	Yes	No
4. When was your sleep study and who was it conducted by? _____		
5. May we contact your physician to obtain your sleep records?	Yes	No

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OFFICE USE ONLY:

Height: _____	BMI: _____	Snore	Family Hx: _____
Weight: _____	Age: _____	Tired	Mallampati: _____
ESS: _____	Neck: _____	Observed	Ortho Class: _____
STOPBANG Score: ____	Gender: M F	Pressure	Crenulations: _____

Calculations Completed: _____

JB Reviewed with Patient: _____

Risk Level: Low + Moderate + High +

Notes:_____

_____

_____

Follow-up:

- ☐ Import into Document Center
- ☐ Create alert to review with patient at next visit
- ☐ Referral to Sleep Specialist
- ☐ _____

_____