TODAY'S DATE:____________________________

PATIENT INFORMATION	
Last Name:	First Name: Nickname: MI:
Street Address:	Patient Gender:
City: State: Zip:	Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated
Mailing Address (if different from above):	If Married, Spouse's Name:
City: State: Zip:	Patient Birth Date (Month/Day/Year):
Home Phone:	Patient Social Security Number:
Cell Phone:	Email Address:
Work Phone:	**Best contact (Circle one):** Home PH Cell PH Text Email
Employer/Position:	Work PH
RESPONSIBLE PARTY INFORMATION (complete if different than patient information above)	
Contact Name:	Relationship:
Social Security Number:	Date of Birth (Month/Day/Year):
Address:	Home Phone:
City: State: Zip:	Cell Phone:
Employer:	Work Phone:
DENTAL INSURANCE INFORMATION	
Primary Insured Name:	Secondary Insured Name:
Home Address (if not listed above):	Home Address (if not listed above):
Primary Insured SSN:	Secondary Insured SSN:
Primary Insured Date of Birth (M/D/Y):	Secondary Insured Date of Birth (M/D/Y):
Primary Insured Employer:	Secondary Insured Employer:
Dental Insurance Company: Dental Claim Address:	Dental Insurance Company: Dental Claim Address:
Subscriber Number: Group Number:	Subscriber Number: Group Number:
EMERGENCY CONTACT: ______________________________ PHONE:____ RELATIONSHIP:____________________________________	Who Referred you to our office: ____________________________ Did you see any of our online information: ❑ Google ❑ YELP ❑ Other

Form: PInfo022017

Initial: _______

Leslie B. Anthony, D. M. D.

Dentistry Perfected

PATIENT MEDICAL HISTORY

Please circle applicable answer. Your answers are for our records only and will be considered CONFIDENTIAL

Approximate date of your last dental exam:_____________________

1. Are you in good health? Yes No
   Has there been any change in your health in the past year? Yes No

2. Name of your physician: _____________________________ Approximate date of your last physical exam:_____________________
3. Is a physician currently treating you? If so, why? _______________________________________ Yes No
4. Have you been hospitalized or had a serious illness within the last five (5) years? Yes No
   Description:____

5. Do you take any pills, drugs, or medicines? Yes No
   If so, what? ____
6. Are there any medications that you are allergic to or cannot take? Yes No
   (such as aspirin, penicillin, morphine, Valium) If so, what? ____
7. Have you experienced an unusual reaction to local anesthetic (e.g. novacaine)? Yes No
8. Are you allergic to latex? Yes No

9. Have you ever had any of the following? (Please check if applicable)

❑ Adenoids removed	❑ Dizziness	❑ Hepatitis A (Infectious)	❑ Osteoarthritis
❑ AIDS	❑ Drug Addiction	❑ Hepatitis B or C	❑ Osteoporosis
❑ Angina/Chest Pain	❑ Eating Disorder	❑ High blood pressure	❑ Pain in jaw joints (TMJ)
❑ Arteriosclerosis	❑ Emphysema	❑ HIV Positive	❑ Psychiatric Diagnosis_________
❑ Asthma / Breathing Problems	❑ Fibromyalgia	❑ Hypoglycemia	❑ Prior orthodontic treatment
❑ Autoimmune disorders	❑ Frequent Cough	❑ Injury to teeth	❑ Radiation
❑ Blood Disease	❑ Frequent sore throat	❑ Jaw Surgery	❑ Recent weight loss
❑ Cancer_______________________	❑ Gastric Reflux	❑ Kidney Problems	❑ Renal Dialysis
❑ Chemotherapy	❑ Glaucoma	❑ Leukemia	❑ Rheumatic Fever
❑ Chronic sinus problems	❑ Hay Fever	❑ Liver Disease	❑ Rheumatoid arthritis
❑ Chronic fatigue	❑ Heart murmur	❑ Learning Disability	❑ Stroke
❑ Cold Sores / Fever Blisters	❑ Heart pounding or beating	❑ Low blood pressure	❑ Thyroid disease
❑ Congenital Heart Disorder	irregularly during the night	❑ Lung Disease	❑ Tuberculosis
❑ Convulsions / Seizures	❑ Heart pacemaker	❑ Memory Loss	❑ Tumors or Growths
❑ Depression	❑ Heart palpitations	❑ Migraines	❑ Ulcers
❑ Diabetes	❑ Heart valve replacement	❑ Morning dry mouth	❑ Venereal Disease / HPV
❑ Difficulty concentrating	❑ Heartburn	❑ Nighttime sweating	❑ Wisdom teeth extraction

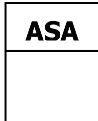
Have you ever had any serious disease/ medical condition not mentioned above? _________ Describe: _____________________
____

10. Do you have an artificial heart valve, hip prosthesis or other implant? Yes No
    If yes, Name of your treating physician: ______________________________ Date of surgery:__________________
11. Cardiovascular:
    Do you have chest pain on mild exertion? Yes No
    Are you short of breath after mild exertion? Yes No
    Do your ankles swell? Yes No
    Do you get short of breath when you lie down or do you require extra pillows when you sleep? Yes No

12. Does your mouth frequently become dry? Yes No
    Is there history of diabetes in your family? Yes No
    Do you have to urinate frequently? Yes No

13. Do you smoke? If YES, how many packs per day:_________ Yes No
    Do you use chewing tobacco? If YES, how many times per day:_________ Yes No

14. Does it make you anxious/nervous to visit the dentist Yes No
15. Have you had any problems associated with previous dental treatment? Yes No
    If yes, please explain____
16. Do you think that your teeth are affecting your general health in any way? Yes No



17. If female, please circle if you are 1) pregnant 2) nursing 3) taking birth control pills

Chief Dental complaint:____

Form: FinPol042018

Initial: ________

FINANCIAL POLICIES

1. Payment is expected in full at the time of service unless a financial payment plan has been agreed upon in advance of treatment. We accept all major credit cards, cash, personal checks and Care Credit.

2. We are not a preferred provider or an in-Network dentist for any insurance carrier.

3. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. The charges submitted to the insurance carrier will become due and payable 90 days from the date of filing if no response or payment is received. If the insurance company denies coverage, payment is due immediately. If secondary insurance is carried, we will file the secondary claim once payment is received from the primary insurance. Explanation of Benefits (EOB) copies are required to submit the secondary claim. If a payment of dental benefits is made to you directly and a secondary insurance is involved, you will need to supply our office with a copy of the EOB so that the secondary claim can be submitted for you.

4. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company; therefore we do not confirm insurance eligibility for recommended treatment. Any insurance information given to you by this office is *strictly an estimate* of benefits and *not a guarantee of payment*. Insurance benefit payments are determined solely by your insurance company and are subject to review of the claim, eligibility status and terms and conditions of your specific policy. This office is not responsible for monitoring patient's insurance policy limitations, waiting periods and plan maximums.

5. All co-payment and deductible amounts are due and payable at the time service is rendered in accordance with the legal requirements prohibiting writing off of patient responsibility amounts. Insurance payments made directly to the patient for services provided by our office and due and payable to us once received by the patient.

6. We do not accept Medicaid.

7. The responsibility for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

8. Our office charges $25 for returned checks.

9. Balances that are 60 days past due are subject to a 1.5% monthly service charge, which is an APR of 18%.

10. If your account is sent to collections, you will be responsible for any and all collection fees, court costs and/or attorney fees.

CANCELLATION POLICY

Our staff is prepared to offer each patient the individual attention necessary to understand and treat your dental needs. To ensure you receive this attention, we set aside dedicated time for each appointment. If you find it necessary to cancel an appointment, we request that you give our office at least 24 hours notice. If appropriate notice is not given, you may be charged $50 for a broken or cancelled appointment.

All cancellation fees must be paid prior to scheduling another appointment.

INFORMED CONSENT FOR DENTAL TREATMENT

I understand there are rare complications and/or side effects to any dental treatment that I might receive. There may be: 1) pain, swelling, inflammation or infection of the area of the injection of local anesthesia, 2) injury to nerves or blood vessels in the area, 3) an allergic or unexpected reaction to materials and/or medications.

Fortunately, these complications and side effects are not common. Most dental treatment is generally very safe, comfortable and well tolerated.

I have given complete and truthful medical history, listing all medications, drug use, pregnancy, etc.

I grant the right to the dentist to release my dental histories and other needed information about my dental treatment to third party payers and/or health professionals.

I certify that I speak, read and write the English language.

I have received and reviewed a copy of the privacy practice notice (HIPPA).

I have read and understand the above risks and give my consent for dental treatment.

I ACKNOWLEDGE I HAVE READ AND AGREE TO ABIDE BY THE FINANCIAL POLICIES & THOSE DESCRIBED ABOVE.

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE: ______________________________ DATE: ____________

REPRESENTATIVE FOR DR. LESLIE B. ANTHONY DMD, PC: ________________________ DATE: ____________

Sleep Screening Questionnaire

Please answer the questions below to help us assess for possible sleep apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep apnea can increase your risk for many health conditions.

Name ____Date_______________

DOB___________________________Height____________________________Weight __________

	Yes	No	
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐	
Are you currently being treated for OSA?	☐	☐	
Are you aware of a family history of OSA?	☐	☐	
Are you aware of clenching or grinding your teeth at night?	☐	☐	
Are you currently using a CPAP?	☐	☐	If YES, how often_____________

ESS: Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze

1 = I have a slight chance of dozing

2 = I have a moderate chance of dozing

3 = I have a high chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	________
2. Watching TV	________
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	________
4. As a passenger in a car for an hour without a	________
5. Lying down to rest in the afternoon when circumstances permit	________
6. Sitting and talking to someone	________
7. Sitting quietly in a lunch without alcohol	________
8. In a car while stopped for a few minutes in traffic	________

STOP –BANG

		Yes	No
1. **S**nore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	☐	☐
2. **T**ired	Do you often feel tired, fatigued or sleepy during daytime?	☐	☐
3. **O**bstruction	Has anyone observed you stop breathing during your sleep?	☐	☐
4. **P**ressure	Do you have or are you being treated for high blood pressure?	☐	☐
5. **B**MI	Do you weigh more for your height than is shown in the table below?	☐	☐
6. **A**ge	Are you 50 years old or older?	☐	☐
7. **N**eck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	☐	☐
8. **G**ender	Are you a male?	☐	☐

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4’10”	167	5’3”	197	5’8”	230	6’1”	265
4’11”	173	5’4”	204	5’9”	237	6’2”	272
5’	179	5’5”	210	5’10”	243	6’3”	279
5’1”	185	5’6”	216	5’11”	250	6’4”	287
5’2”	191	5’7”	223	6’	258	6’5”	295
Weights shown in the tables above correspond to BMI of 35 for a given height.							

Patient Signature ____