ACQUAINTANCE FORMS

In this section are three separate forms that are very important.

Before your first visit you must take the necessary time to accurately fill them out.

This should be done when you are not rushed and can candidly reveal any past fears, disappointments or problems you may have experienced in Dentistry.

The more we know about you, the better we will be able to serve you.

PATIENT INFORMATION

Date_____, _____, _____

Patient's Name — Last _____ First _____ Middle _____ Nickname _____ O Male O Female

Address _____
Street City State Zap

Home Phone (____)_____ Work Phone (_____)_____ Birthdate_____

Cell Phone (_____) _____
If a child, give patient's guardian name _____ _____ Social Security No._____
Last First Middle

RESPONSIBILITY PARTY INFORMATION

Name_____ _____ _____ Marital Status_____
Last First Middle Nickname

Address _____ Street — City State Zip —

Birthdate _____

Home Phone (____)_____ Work Phone (_____)_____ Social Security No._____

Employer_____ Occupation_____

Spouse's Name_____ _____ Birthdate_____
Last First Middle Nickname

Home Phone (_____)_____ Work Phone (____)_____

Employer_____ Occupation_____

DENTAL INSURANCE INFORMATION

Insured's Name _____ _____ Insured's Social Security No._____
List First Middle

Dental Insurance Company _____ Group No._____ Agreement No._____

Insurance Company Address_____ _____
& — C &m

Insurance Co. Phone (_____) _____ Date of Employment_____ Effective Date of Dental Insurance _____

Insured's Employer_____ Employer's Address _____

Employer's Phone (____)_____ Do you have dual coverage? O No O Yes If yes, complete the following:

Insured's Name _____ _____ Insured's Social Security No. _____
Last First Middle

Dental Insurance Company_____ Group No._____ Agreement No._____

Insurance Company Address_____ _____
Street City State Zip

Insurance Co. Phone (_____) _____ Date of Employment _____ Effective Date of Dental Insurance _____

Insured's Employer_____ Employer's Address _____

Employer's Phone (_____)_____

EMERGENCY NOTIFICATION INFORMATION

In case of emergency, who should be notified?

Name _____ Phone (____) _____

REFERRAL INFORMATION

Whom may we thank for referring you to our office'

Name_____ Address _____

DENTAL QUESTIONNAIRE

Last First Middle Nickname

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? O Yes O No

2. Have you ever had any serious trouble associated with previous dentistry? O Yes O No

3. Does dental treatment make you nervous? O No O Slightly O Moderately O Extremely

4. Date of last dental visit?_____

5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? O No O Yes

6. How often do you brush?_____ Brush is: O soft O medium O hard

7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	O Yes	O No
Unpleasant taste/bad breath	O Yes	O No
Burning tongue/lips	O Yes	O No
Frequent blister, lips/mouth	O Yes	O No
Swelling/lumps in mouth	O Yes	O No
Ortho treatments (braces)	O Yes	O No
Biting cheeks/lips	O Yes	O No
Clicking/popping jaw	O Yes	O No
Difficulty opening or closing jaw	O Yes	O No

TEETH

Loose teeth	O Yes	O No
Sensitive Lo hot	O Yes	O No
Sensitive to cold	O Yes	O No
Sensitive to sweets	O Yes	O No
Sensitive to biting	O Yes	O No
Food impaction	O Yes	O No

Clenching/ grinding

If so, when _____

Shifting in bite	O Yes	O No
Change in bite	O Yes	O No

8. Do you use the following?

Brush: O Yes O No Dental floss: O Yes O No Fluoride: O Yes O No Other_____

These are the things that are important to me about my dental health_____

_____

_____

What do you fear most about dental care? _____

Do you: O Dread it? O Worry about it? O Don't mind it O

Circle One:

1. My mouth is
   a) very comfortable
   b) moderately comfortable
   c) uncomfortable

2. I
   a) think the appearance of my mouth is excellent
   b) am satisfied with the appearance of my mouth
   c) am dissatisfied with the appearance of my mouth

3. I
   a) will do anything to keep my natural teeth
   b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them

4. I
   a) have set goals for my oral health with a previous dentist
   b) want to set goals concerning my dental health

5. I
   a) have always done the best that was recommended for my dental health
   b) have not done what dentists have recommended to me
   c) rarely go, and don't care much about having any dental work completed

6. I
   a) have put dentistry for myself and my family high on my priority list
   b) put dentistry for myself and my family low on my priority list
   c) put dentistry on my list, but it's hard to find

7. I think my present state of dental health is
   a) Excellent
   b) Good
   c) Poor

What are some questions about dentistry and oral health that you have never had adequately answered?_____

_____

_____

MEDICAL QUESTIONNAIRE

Correct answers to the following questions will allow your dentist to treat you so there WILL NOT be an emergency. However, if an emergency situation does arise, this information will help insure your proper treatment. As before, your answers are for our records only and will be considered confidential.

General health (please check): O Excellent O Good O Fair O Poor

Name and address of your physician ———————————————————————

Last complete physical ———————————————————————

Are you presently under the care of a physician? O Yes O No
If so, for what reason? _____

Are you taking any medication now? O Yes O No
If yes, please list all medications _____

Are you allergic to: O Antibiotics O Codeine O Aspirin O Local Anesthetics
Or any other medications? ———————————————————————

Have you ever been hospitalized? If so, give name of hospital, reason, and dates ———————————

Have you had any radiological diagnostic x-rays in the last five years? O Yes O No
Have you had any blood transfusions? 0Yes O No
Are you currently trying to modify your weight? O Yes O No
Do you take any medications to help in weight reduction? O Yes O No
Do you smoke cigarettes? O Yes O No How many per day? _____
Do you consume alcohol on a daily basis? O Yes O No
Is your blood pressure: O Normal O High O Low O I don't know
Have you experienced any recent weight change? 0Yes O No
Women: Are you pregnant? O Yes O No How long_
Have you had cortisone or steroids within the past year? O Yes O No
Do you have or have you ever been informed that you had any of the following:

Chest Pains	O Yes O No	Bruise Easily	O Yes O No
Heart Disease	O Yes O No	Jaundice	O Yes O No
Rheumatic Fever	O Yes O No	Asthma or Hay Fever	O Yes O No
Congenital Heart Defects	O Yes O No	Allergies or Hives	O Yes O No
Heart Murmur	O Yes O No	Sinus Trouble	O Yes O No
Mitral Valve Prolapse	O Yes O No	Arthritis	O Yes O No
Fainting Spells	O Yes O No	Excessive Urination and/or Thirst	O Yes O No
Hypertension	O Yes O No	Persistent Cough	O Yes O No
Kidney Problems	O Yes O No	Prolonged Bleeding Problems	O Yes O No
Stroke	O Yes O No	Sexually Transmitted Diseases:	
Hepatitis	O Yes O No	(Gonorrhea, Syphilis, Genital Herpes)	O Yes O No
Thyroid Problems	O Yes O No	Genetic Problems	O Yes O No
Hormonal Problems	O Yes O No	Skin Disease	O Yes O No
Ulcers	O Yes O No	AIDS	O Yes O No
Tuberculosis or Lung Disease	O Yes O No	Unexplained Fevers	O Yes O No
Diabetes	O Yes O No	Prolonged Sore Throat	O Yes O No
Epilepsy or Seizures	O Yes O No	Enlarged Lymph Nodes	O Yes O No
Anemia	O Yes O No	Night Sweats	O Yes O No
Cancer or Leukemia	O Yes O No	Persistent Diarrhea	O Yes O No
Psychiatric Problems	O Yes O No	Bluish-Reddish Lesions	O Yes O No
Glaucoma	O Yes O No	Fatigue	O Yes O No
Prosthetic Valves or Joints	O Yes O No	Sickle Cell Disease	O Yes O No

Do you have a history of cold sores, fever blisters or canker sores? O Yes O No
Are you being treated with immunosuppressive drugs? O Yes O No
Have you ever used drugs for recreational purposes? O Yes O No
Were you advised by your physician Lo be premedicated with an antibiotic prior to dental treatment? O Yes O No

THE ROYERSFORD DENTIST
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Informed Consent for Treatment

It is very important for me, Dr. Eric Paster, that as my patient, you understand the treatment plan I am recommending. It is imperative that you understand any invasive procedures I perform; I want to involve you in all of the decisions concerning these procedures and I want you to understand that there are risks associated with dental procedures. Your signature affirms that you understand these risks and that all of your questions have been answered to your satisfaction.

INITIALS:_____ **DATE:**_____

Dental treatment and procedures are not to be taken as routine and without risk for complications. As with all medical treatments, there are differences in how each person's body will react. There are no guarantees that the results of the treatment will be the same as what is planned for. When dealing with individuals there are many potential variables, some of which are predictable and others which are not. Complication rates in dentistry are low but do exist. Even a minor procedure such as a filling can lead to unforeseen major complications. Some local anesthetics may cause an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, hospitalization, and even death. These extreme reactions are uncommon. Individuals who are contemplating treatment should be aware of this prior to signing informed consent. Whenever drilling is involved in treatment, pulpal (nerve) damage, abscess, fractured teeth, post-treatment pain, sensitivity to hot and cold, and altered bite may result. These complications can be temporary or may persist, requiring further treatment. Generally, pain, bleeding, swelling, infection, tooth fractures, and nerve problems can occur. The above list is not all inclusive.

COMMITMENT TO TREATMENT: We believe that all treatment begun should be completed. Incomplete treatment leads to further dental problems, complications, loss of teeth, and additional disease. This policy states that all agreed to treatment plans, once started, will be completed. To begin staged treatment, your commitment to both starting and completing that treatment is required.

Dr. Eric Paster reserves the time for each patient to complete procedures. An appointment in our schedule is a bond of trust between us as providers, and you as patients. This infers that we will provide care on time and to the best of our ability, and that we will have the proper number of qualified staff to meet your needs. You as the patient agree to be present for your appointment and meet all financial obligations. Please see our financial policy for all billing and payment information.

SIGNED: _____ **DATE:**_____

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STOPBANG Questionnaire

Why are we asking about your sleep?

Although dentistry is not commonly thought of as a screening modality for sleep apnea, it is often the first line of defense in leading patients to learn about and seek treatment for sleep airway issues. There are many oral signs and symptoms of sleep disorder breathing that your dental team can observe.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you haven't done some of these things recently, try to work out how they would have affected you. For each situation, decide whether or not you would have:

These four, yes or no "STOP" questions can help you determine your risk:

Snoring: Do you snore **loudly** (louder than talking or loud enough to be heard through closed doors)? ☐ YES ☐ NO

Tired: Do you often feel **tired**, fatigued or sleepy during the day? ☐ YES ☐ NO

Observed: Has anyone **observed** you not breathing during sleep? ☐ YES ☐ NO

Pressure: Do you have or have you been treated for high blood pressure? ☐ YES ☐ NO

Body Mass Index more than 35 kg/m^2? Height (inches) _____ Weight (lbs) _____
****Office use only for calculation:** BMI = _____
BMI = Weight in Pounds x 703 / (Height in inches) x (Height in inches)

Age older than 50 years old? ☐ YES ☐ NO

Neck size large? (Measured from Adams apple)
For **MALE**, is your shirt collar 17inches / 43cm or larger? ☐ YES ☐ NO
For **FEMALE**, is your shirt collar 16in / 41cm or larger? ☐ YES ☐ NO

Gender is male? ☐ YES ☐ NO

FOR OFFICE USE ONLY:

RESULTS for general population:

OSA - Low Risk : Yes to 0 - 2 questions
OSA - Intermediate Risk : Yes to 3 - 4 questions
OSA - High Risk : Yes to 5 - 8 questions
or Yes to 2 or more of 4 STOP questions + male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m2
or Yes to 2 or more of 4 STOP questions + neck circumference 17 inches / 43cm in male or 16 inches / 41cm in female