Registration And Health History Form

Name _____ **What do you prefer to be called** _____ **Date** _____

Home Phone (____) _____ **Cell** (____) _____ **Work** (____) _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth _____ **Sex M F** **Occupation** _____ **S S #** _____

If you are completing this form for another person, what is your relation? _____ Who may we thank for this referral? _____

Emergency Contact _____ **Phone Number** _____ **Relationship** _____

Signature of responsible party: _____

Dental Insurance Carrier _____ ID# _____ Group# _____

Check this box only if the Insured person (the person receiving dental service) is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS# _____ Insured's Date of Birth _____

Relationship to Insured: _____ Employer of Insured: _____

Dental Information

Yes	No	Unknown	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Do you wear removable/fixed dental appliances?
☐	☐	☐	Have you been told you have periodontal (gum) disease?
☐	☐	☐	Are you aware of loose teeth or broken fillings?
☐	☐	☐	Are your gums swollen or tender?
☐	☐	☐	Are you a mouth breather?
☐	☐	☐	Do you frequently get blisters on lips or mouth?
☐	☐	☐	Do you have a family history of periodontal disease?
☐	☐	☐	Do you ever get a burning sensation on tongue?
☐	☐	☐	Do you chew on one side of mouth?
☐	☐	☐	Do you get clicking or popping of your jaw?
☐	☐	☐	Do you get jaw pain or tiredness?
☐	☐	☐	Does food collect between your teeth?
☐	☐	☐	Do you have pain when brushing?
☐	☐	☐	Do you or have you been told you grind your teeth?

Have you had any problems associated with previous dental treatment or past dental experiences?

☐ Yes ☐ No

If so, explain: _____

Oral Habits *(Check all that apply)*

☐ Tongue/lip piercing ☐ Ice chewing ☐ Using teeth as a tool
☐ Do you bite your nails/foreign objects?
☐ Musical instrument with mouthpiece

What fluoride products do you use/consume? *(Check all that apply)*

☐ Toothpaste ☐ Water ☐ Rinses
☐ Other _____

What are the three most important factors you desire from your dental office?

1. _____
2. _____
3. _____

Do you have any problems with bad breath?

How often do you floss? _____ /day
How often do you brush? _____ /day

Do you have a history of tongue tie? ☐ Yes ☐ No
Difficulty swallowing? ☐ Yes ☐ No

DR. SNYDER

MEDICAL INFORMATION

Physician(s) _____ **Phone** (____) _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Yes	No	Unknown	
☐	☐	☐	Are you in good health?
☐	☐	☐	Have there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated? _____ _____ Date of last exam _____
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem? _____
☐	☐	☐	Do you consume snacks/beverages containing sugar between meals? ☐ Yes ☐ No How many times per day? _____
☐	☐	☐	Do you snore?
☐	☐	☐	Do you wake up feeling refreshed?
☐	☐	☐	Have you ever been told you have sleep apnea?
☐	☐	☐	Have you ever worn a CPAP? If yes, do you use it regulary: Please explain: _____

What is your alcohol consumption history?

- ☐ **Light drinker:** Consumed ≥ 12 drinks in past year and <3 per week on average
- ☐ **Moderate drinker:** Consumed 3 to >14 drinks per week on average in past year
- ☐ **Heavy drinker:** Consumed ≥ 2 to >3 drinks per day on average in past year
- ☐ **Abuser:** Consumed ≥ 3 drinks per day on average in past year

What is your history of tobacco use; Marijuana

Cigarette, cigar or pipe use

- ☐ Never smoked cigarettes Age Began ____ Year Quit ____
- ☐ Former smoker
- ☐ <10 per day
- ☐ ≥10 per day

Smokeless tobacco use

- ☐ Never used smokeless tobacco Age Began ____ Year Quit ____
- ☐ Former smoker
- ☐ <10 per day
- ☐ ≥10 per day

Are you allergic to or have you had a reaction to?

Yes	No	Unknown	
☐	☐	☐	Local Anesthetics
☐	☐	☐	Penicillin or other antibitoics
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Sulfa Drugs
☐	☐	☐	Codeine or other narcotics

Yes	No	Unknown	
☐	☐	☐	Latex
☐	☐	☐	Iodine
☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Metal

Are you taking any medications (Prescription or Over-the-Counter)?

Name of Drug	Purpose	Date

DR. SNYDER

Please list any drugs or medicines that you cannot or prefer to not take because of allergies or side-effects especially antibiotics for infections, analgesics for pain, and anesthetics. _____

What is your preferred drug for mild and/or severe pain? _____

What is your preferred antibiotic for an infection? _____

List any street/recreational drugs you use: _____

PLEASE (X) A RESPONSE TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

Yes	No	Unknown	
☐	☐	☐	Abnormal Bleeding
			Controlled? (circle one): Good Fair Poor
			_____
☐	☐	☐	AIDS or HIV
☐	☐	☐	Anemia
☐	☐	☐	Herpes
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood Transfusion If yes, date _____
☐	☐	☐	Cancer/Chemotherapy/Radiation
☐	☐	☐	Cardiovascular diseases?
			☐ Angina Pectoris ☐ Heart Murmur
			☐ Bypass Surgery ☐ Mitral Valve Prolapse
			☐ Pacemaker ☐ Rheumatic Fever
			☐ Artificial Valves
			☐ Heart Attack Date _____
☐	☐	☐	Chest Pain/Shortness of breath upon exertion
☐	☐	☐	Chronic Pain
☐	☐	☐	G.E. Reflux, persistent heartburn, or Gastrointestinal Disease
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, Jaundice, or Liver Disease
☐	☐	☐	High/ Low Blood Pressure
☐	☐	☐	Recurrent Infection If yes, what type of infection?
			_____
☐	☐	☐	Diabetes
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Dry Mouth
☐	☐	☐	Joint Replacement
☐	☐	☐	Eating disorder If yes, please specify
			_____

Yes	No	Unknown	
☐	☐	☐	Disease, drug or Radiation-induced immunosuppression
☐	☐	☐	Mental Health disorder
☐	☐	☐	Night sweats/ Menopausal
☐	☐	☐	Neurological disorders
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands
☐	☐	☐	Respiratory problems
			If yes, please specify:
			☐ Emphysema ☐ Bronchitis, etc
☐	☐	☐	Severe headaches/migraines
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus Trouble
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke If yes, date _____
☐	☐	☐	Systemic Lupus Erythematosus
☐	☐	☐	Tuberculosis
☐	☐	☐	Thyroid problems
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination/thirst

Do you have any disease not listed above that you think we should know about? Please explain: _____

_____

☐	☐	☐ Have you ever been told you needed to Pre-medicate for dental treatment?
☐	☐	☐ Are you pregnant?
☐	☐	☐ Are you planning to be pregnant?

Please feel free to add any additional information you would like us to know about your medical or dental care:

_____

_____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing her treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Laura Snyder, DDS unless otherwise indicated.

_____ _____

Signature of Patient/Legal Guardian **Date**

DR. SNYDER

Cosmetic/Esthetic Evaluation

How do you feel about the appearance of your teeth?_____

Are you delighted with your smile? (circle one) Yes or No

Please rate your smile from 1 to 10 (1=I hate my smile, 10=Awesome):_____

Would you like to have whiter teeth? Yes or No

If you had a magic wand, what, if anything,would you change about your smile?_____

Do you have any special occasions coming up?_____

Would you like to have a new and improved smile? Yes or No If you marked yes, please check all that apply. ☐ Lighten all front teeth showing

☐ Lighten single tooth ☐ Close spaces between teeth ☐ Smoother skin ☐ Rebuild fracture(s) ☐ Lengthen teeth ☐ Shorten teeth ☐ Thicker lips

☐ Straighten rotation ☐ Straighten angulation ☐ Eliminate crowding ☐ Removal of wrinkles ☐ Eliminate dark or stained fillings

☐ Reduce gum showing in smile ☐ Repair uneven edges

Assessment of Daytime Sleepiness: Epworth Sleepiness Scale

Please complete the questions below. This is a measure of dozing or falling asleep, not just feeling tired. This is to reflect how you have felt most recently. Use the following scale to chose the most appropriate number (0-3) (0 Never 3 always) in each of the 9 boxes:

Chance of Dozing (0-3) Situation

_____Sitting and reading

_____Watching TV

_____Sitting inactive in a public place

_____A theatre or meeting

_____As a passenger in a car for an hour without a break

_____Lying down to rest in the afternoon

_____Sitting and talking to someone

_____Sitting quietly after lunch (when you've had no alcohol)

_____In a car while stopped for traffic

Total = Scoring: 1-6 enough sleep, 7-8 average score, 9 & up should consult a sleep professional.

Y N 1. Do you SNORE loudly?

Y N 2. Do you often feel TIRED, fatigued or sleepy?

Y N 3. Have you been OBSERVED to stop breathing during sleep?

Y N 4. Are you being treated for or do you have high blood PRESSURE?

If you answered positive to two (2) or more, you have a high risk for OSA

HIPPA OMNIBUS RULE - PATIENT ACKNOWLEDAGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we ***may not be allowed*** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES, AND FOR ANY DENTAL OR MEDICAL INSURANCE CLAIMS THAT REQUIRE A SIGNATURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

-- Cell Phone Confirmation
-- Home Phone Confirmation
-- Work Phone Confirmation
-- Text Message to my Cell Phone
-- Email Confirmation
-- **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

-- Cell Phone Confirmation
-- Home Phone Confirmation
-- Work Phone Confirmation
-- Text Message to my Cell Phone
-- Email Confirmation
-- **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

* Phone Message
* Text Message
* Email
-- **Any of the Above**
-- **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

DR. SNYDER

DENTAL TREATMENT CONSENT FORM

Date: _____ Patient Name: _____ Birth Date: _____

*Some of the following may apply to you and your future treatment

1. GENERAL RISKS OF DENTAL CARE

Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as: antibiotics, analgesics (pain medications), and local anesthetic injection. These complications may include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, teeth; which is transient but on infrequent occasions may be permanent; reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

2. SPECIFIC RISKS

The treatment that we have recommended is intended to correct conditions in your mouth that can ultimately lead to worsening complication or tooth loss. During treatment, complications may be discovered which make treatment impossible, or which may require corrective dental surgery. These complications may include exposure of the tooth pulp or fractures of the teeth. Usually these complications are due to the condition of the gums and/or bone or previous restorations and cannot be foreseen either by clinical or radiological examination.

3. MEDICATIONS

Some prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Some antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Women who are taking oral contraceptives, and are given a prescription for an antibiotic, are strongly advised to use additional means of birth control during the entire monthly cycle for which the antibiotic has been used.

4. OTHER TREATMENT CHOICES

These include no treatment, waiting for more definitive development of symptoms, and tooth extraction. Risks involved in these choices may include pain, infection, swelling, loss of teeth, and spread of infection in other areas. The risks of these alternative treatments are often more severe than those of root canal therapy.

5. CONSENT

I the undersigned being the patient (parent or guardian of patient) consent to performing the procedures decoded to be necessary or advisable in the opinion of the doctor. I understand that this treatment is an attempt to save a tooth, and that even though this therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had previous treatment may require more treatment, corrective surgery, or even extraction. **I hereby authorize Dr. Snyder and staff to perform the needed treatment upon me (or the named patient)**

_____ _____

Patient, Parent, or Guardian Signature **Date**

DR. SNYDER

COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
  Which would you prefer? ☐ Tylenol ☐ Advil ☐ Other: _____

- We provide various levels of sedation to ease your mind.
  Would you benefit from a sedative?..... ☐Yes ☐No

  If yes, we provide: ☐ Mild sedative (oral medication)
  (Note: With mild sedative, you will need someone to drive you to and from the appointment.)

- We now offer Dental Vibe. Dental Vibe is the first product to deliver soothing vibration that helps bypass the pain of dental injections.
  Would you be interested in learning more about it?..... ☐Yes ☐No

- We also have wireless headphones linked to Pandora for your use with personalized playlists.
  Would you like to listen to music during your visits?..... ☐ Yes ☐ No
  Please provide a list of the artists or type of music you like so we can load them for your next visit.

- Aromatherapy with therapeutic grade essential oils to soothe the nervous system.
  Would you be interested in having this available at your visit? ☐ Yes ☐ No
- Blankets help keep you warm and relaxed through your visit.
  Would you like a blanket?..... ☐Yes ☐No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
  Would you like a pillow?..... ☐Yes ☐No

- Is there anything else we can do to make your visit comfortable?

4830 Juan Tabo Blvd NE Ste K • Albuquerque, NM 87111 • (505) 293-7611| **www.bestalbuquerquedentists.com**

DR. SNYDER

Please Handle Me With Care

_____

Patient Name

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down for a long time, and I feel uncomfortable about what you will say about my teeth and hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I am interested in oral sedation: for adults who need a deeper state of sedation

Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me, how each dental procedure will work, and how much of my time will be required.

DR. SNYDER

APPOINTMENT AGREEMENT

Welcome to our wonderful family of patients! Thank you for selecting us as your dental care team. We are confident your relationship with us will be a pleasant and rewarding one! We provide our patients with the best clinical care possible in a warm, caring, comfortable environment. In order for us to respect the time of all of our patients, we ask that you help us in regards to the appointments that have been specifically reserved for you!

PLEASE BE ON TIME FOR YOUR APPOINTMENTS.

Your appointment time is reserved specifically for you. Arrivals of 10 minutes or more past your reserved time will be rescheduled and a fee assessed per scheduled appointment.

DEPOSITS

For certain complex treatment plans we do ask for a deposit to reserve this time for you which is an agreed commitment to keep your reserved appointment time. This deposit will be applied to your portion of your responsibility for the appointment with the balance due at the time of service. If 48 hours' notice is not given for any appointment changes, the deposit would be non-refundable.

WE REQUIRE 48 HOURS (business day) NOTICE WHEN CHANGING OR RESCHEDULING. This allows us to offer your time slot to another patient who is in need of our care.

If 48 hour notice is not given or you fail to show up for your appointment at your scheduled time, we will assess a fee.

*There is a $35 charge for returned checks.

Dental Insurance: All services are charged directly to the patient; and patients are personally responsible for payment at the time of service. Our office will prepare the necessary reports to assist you in collecting benefits from your insurance company.

We thank you for your understanding and partnership in this matter!

My signature indicates that I have read this and agree to its contents.

_____ _____

Name (first, last) Date

_____

Scheduling Coordinator