Patient

Name_____ What name would you like us to call you? _____

Address_____Zip_____

Best Phone #_____ Cell phone #_____Work#_____

Your employer: _____ Occupation: _____

Social Security # _____-_____-_____ Date of Birth _____

Whom may we thank for referring you? _____

Marital Status (check one): Married_____ Unmarried_____ Separated_____ Widowed_____

Sex: (Circle one) Male or Female Email address:_____

Who is responsible for this account? _____ Relationship to patient? _____

Emergency contact? (not in your household) Name _____Phone# _____

Other family members that are seen by us: _____

==========

Do you have Dental Insurance Coverage? YES/NO Secondary Coverage? YES/NO

Insurance Company_____

Employer_____ **Group #** _____**ID or SSN#**_____

Name of the Insured_____ **Subscriber's Date of Birth**_____

Patient's relationship to the subscriber _____

I state here that the preceding information is correct. I understand that payment is due as services are rendered unless other arrangements have been made in advance and that my portion of insurance filed is due at the time of service. I authorize my insurance company to pay directly to the dentist and understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents. I also understand that I am responsible for all collection charges including attorney fees, court costs and interest charges.

If I am delinquent in paying my account, I agree to pay interest on the overdue balance at a rate of 15% per month. I understand that my health history information will be used as necessary for diagnosis or treatment.

SIGNATURE: _____***DATE:***_____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years _____
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver,_____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea)_____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements_____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

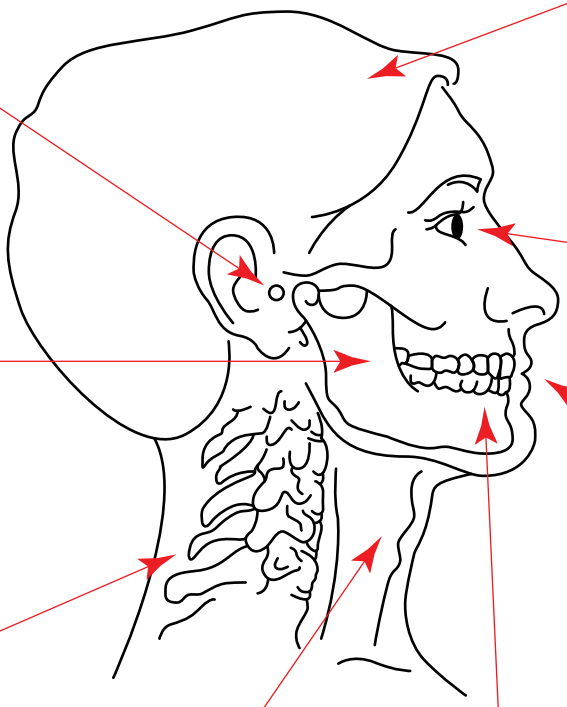
DAILY ROSEN dentistry

Tell us about your symptoms

On the lines below please write down your head and neck symptoms.
Begin with the symptom that is most important to you and continue the list in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

On the visual illustration below please check the items that pertain to you.
Using a scale of 1 to 10 (with 10 being extremely severe), rate the severity of each symptom you have circled.



EAR PROBLEMS
1. Hissing, buzzing or ringing ☐
2. Decreased hearing ☐
3. Ear pain, ear ache, no infection ☐
4. Clogged "itchy" ears ☐
5. Vertigo, dizziness ☐

HEAD PAIN, HEADACHE
1. Forehead ☐
2. Temples ☐
3. "Migraine" typle ☐
4. Sinus type ☐
5. Shooting pain up back of head ☐
6. Hair and/or scalp painful to touch ☐

EYES
1. Pain behind eye ☐
2. Bloodshot eyes ☐
3. May bulge out ☐
4. Sensitive to sunlight ☐

JAW PROBLEMS
1. Clicking, popping jaw joints ☐
2. Grating sounds ☐
3. Pain in neck muscles ☐
4. Uncontrollable jaw and/or tongue movement ☐

MOUTH
1. Discomfort ☐
2. Limited opening of mouth ☐
3. Inability to open smoothly ☐
4. Jaw deviates to one side when opening ☐
5. Locks shut or open ☐
6. Can't find bite ☐

NECK PROBLEMS
1. Lack of mobility, stillness ☐
2. Neck pain ☐
3. Tired sore muscles ☐
4. Shoulder aches backaches ☐
5. Arm and finger numbness and/or pain ☐

THROAT
1. Swallowing difficulties ☐
2. Laryngitis ☐
3. Sore throat with no infection ☐
4. Voice irregularities or changes ☐
5. Frequent coughing or constant clearing of throat ☐
6. Feeling of foreign object in throat constantly ☐

TEETH
1. Clinching, grinding at night ☐
2. Looseness and soreness of back teeth ☐

Patient's Name _____ Date _____

DAILY ROSEN dentistry

Patient Name: _____ Date: _____
First *Middle* *Last*

EPSS 00

Epworth Sleepiness 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 haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

Scoring
0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

If your score is 10 or over, then you may have a sleep disorder!

	Situation	*Pre-OAT / With OAT
1.	Sitting and reading	____/____
2.	Watching TV	____/____
3.	Sitting inactive in a public place (i.e. a theater or a meeting)	____/____
4.	As a passenger in a car for an hour without a break	____/____
5.	Lying down to rest in the afternoon when circumstances permit	____/____
6.	Sitting and talking to someone	____/____
7.	Sitting quietly after lunch without alcohol	____/____
8.	In a car, while stopped for a few minutes in traffic	____/____
	Total Score:	____/____

*Pre-OAT areas do not change

Dio L. Daily, D.D.S. & Alan M. Rosen, D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Phone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about you protected health information. A copy of our Notice accompanies this Consent. We encourage you to read It carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Name: **Alan M. Rosen, D.D.S**

Address: **2740 S. Glenstone, Suite 201**
Springfield, MO 65804

Email: **office@dailyrosen.com**

Phone: **(417) 883-5212**

Fax: **(417) 883-1028**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you If you revoke this Consent.

SIGNATURE

I, _____ . have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that. by signing this Consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

CHART NUMBER: _____
(OFFICE USE ONLY)

DAILY ROSEN dentistry

Dio L. Daily, D.D.S. & Alan M. Rosen, D.D.S

Patient Name: _____ Date: _____
LAST, FIRST M (PREFERRED NAME)

Email: _____ Family Status: _____

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Daily and Rosen D.D.S., L.L.C. to upload and store confidential patient information - including account information, appointment information and clinical information - to the secured web site for Daily and Rosen D.D.S., L.L.C .. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Daily and Rosen D.D.S., L.L.C. and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Daily and Rosen D.D.S., L.L.C. is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Daily and Rosen D.D.S., L.L.C. is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Daily and Rosen D.D.S., L.L.C. web site with my ID and password. I also agree to immediately notify Daily and Rosen D.D.S., L.L.C. of any unauthorized use of my ID or of any other need to deactivate my 1ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Daily and Rosen D.D.S., L.L.C. will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Daily and Rosen D.D.S., L.L.C. has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Daily and Rosen D.D.S., L.L.C. will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Daily and Rosen D.D.S., L.L.C. CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Daily and Rosen D.D.S., L.L.C., and grant Daily and Rosen D.D.S., L.L.C. permission to securely upload my patient information to the web site.

_____ DATE: _____ RELATIONSHIP TO PATIENT: _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN