Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City: State: Zip:
Occupation:
Height: Weight: Date of Birth: Sex: M F
SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )
If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )
Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?
Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: _____ Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Berson Dental Health Care

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The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0 (no chance of dozing to a 3 (high chance of dozing). When you finish the test, add up the values of yor responses. Your total score is based on a scale of . 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you would have.

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

301 City Line Avenue Bala Cynwyd, PA 19004 610-667-6666 bersondental@yahoo.com

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Sleep Consultation

Name:_____ Date:_____

D.O.B:_____ ☐Male ☐Female

What are your chief complaints for which you are seeking treatment?

Please number your complaints with #1 being the most severe. #2 the next most severe, etc. you may assign the same number more than once. You do not need to number every item, only those which present as your chief concerns.

Sleep Breathing Complaints

____ CPAP intolerance
____ Daytime Tiredness
____ Difficulty falling asleep
____ Fatigue
____ Decreased concentration
____ Depression
____ High Blood Pressure
____ Gasping when you wake up
____ Loud Snoring
____ Never Feel Rested
____ Nighttime Choking Spells
____ Obesity
____ Significant Day Time Drowsiness
____ Sleepy While Driving
____ Witnesses Apneic Events
____ Frequent Heavy Snoring

TMD/Pain Complaints

____ Difficulty Swallowing
____ Dizziness
____ Facial Pain
____ Headaches
____ Jaw Clicking
____ Jaw Locking
____ Jaw Pain
____ Limited Mouth Opening
____ Migraines
____ Morning Head Pain
____ Morning Hoarseness
____ Neck Pain
____ Nocturnal Teeth Grinding
____ Pain When Chewing
____ Ringing in the Ears
____Frequent Heavy Snoring affecting sleep of others.

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Sleep Studies

Have you ever had an evaluation at a sleep center ? ☐ Yes ☐ No
If yes, Please complete the "Sleep Records Request Form" on the next page.

Have you been previously diagnosed with Obstructive Sleep Apnea ? ☐ Yes ☐ No

If yes, how long ago was it ? _____ ☐ Years ago ☐ Months ago ☐ Days ago

Other Therapy Attempts
What other therapies have you had for breathing disorders?

☐Yes ☐ No – Dieting

☐ Yes ☐ No – Weight loss

☐ Yes ☐ No – Surgery (Uvuloplasty)

☐ Yes ☐ No – Surgery (Uvulectomy)

☐ Yes ☐No – Pillar procedure

☐ Yes ☐ No – smoking cessation

☐ Yes ☐No – CPAP

☐ Yes ☐ No – BiPap

☐ Yes ☐ No – Uvulectomy (but continues to have symptoms)

☐ Yes ☐ No – Uvuloplasty (but continues to have symptoms)

If you have attempted treatment with a CPAP device, but could not tolerate it, please complete the next form.

_____ _____

(Patient Signature) *(Date)*

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Affidavit for Intolerance or Non Compliance to CPAP

I,_____, have attempted to use CPAP (Continuous Positive Air
(Patient Name)
Pressure) to manage my sleep related breathing disorder (OSA- Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s): *(Check all that Apply)*

☐ Mask Leaks

☐ An Inability to get the mask to fit properly

☐Discomfort caused by the straps and headgear.

☐Disturbed or interrupted sleep caused by the presence of the device

☐Noise from the device disturbing sleep or bed partner's sleep.

☐CPAP restricted movements during sleep

☐CPAP does not seem to be effective

☐Pressure on the upper lip causes tooth related problems

☐Latex allergy

☐Claustrophobic associations

☐An unconscious need to remove the CPAP apparatus at night

☐Other _____

Because of my intolerance/inability to use the CPAP, I wish to have my OSA treated by Oral Appliance therapy utilizing a custom fitted Mandibular Advancement Device

_____ _____

(Patient Signature) *(Date)*

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Sleep Apnea Documentation Request Form

Date: _____

I, _____ authorize release of my sleep record(s) to:

Berson Dental Health Care
301 City Line Avenue, Suite T2
Bala Cynwyd, Pa 19004
Phone: 610 667-6666
Fax: 610 667-5106

_____

Street Address *City* *State* *Zip*

_____ _____ _____

Home Phone *Mobile Phone* *Work Phone*

_____ _____

(Patient Signature) *(Social Security #)*

We have been asked to provide an oral sleep appliance/mandibular advancement device for our mutual patient for the treatment of obstructive sleep apnea. In order to obtain coverage from his/her medical insurance carrier we need you to provide us with the following:

☐ A Referral Letter

☐A Letter of Medical Necessity

☐Copy of Polysomnogram Report

☐A Prescription for Oral Sleep Appliance Therapy

*Please fax the requested information to our office at your earliest convenience.

Thank you in advance for your assistance . vf

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Insurance Form

Primary Dental Insurance:_____ ID#_____

Group#_____

☐ Check this box **ONLY** if the insured person (the person receiving dental service) is the same as applicant on health history. If not enter insured info below.

Name of Insured:_____ Insured's SS#_____

Insured's DOB:_____ Relationship to Insured:_____

Employer of Insured:_____ ☐Full-time ☐Part-time ☐Retired

City:_____ State:_____ Zip:_____

Who is financially responsible for this account _____ Phone#_____

Other Insurance: _____ ID#_____

Group#_____

Name of Insured:_____ Insured's SS#_____

Insured's DOB:_____ Relationship to Insured:_____

Employer of Insured:_____ ☐Full-time ☐Part-time ☐Retired

City:_____ State:_____ Zip:_____

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 Berson Dental Health Care unless otherwise indicated.

Signature:_____ Date: _____

*Your signature indicates you have received a copy of the HIPAA law and Dental materials forms as well as releasing Dr. Berson to utilize any dental photographs for lecturing, educational purposes, and promotional materials.

Berson Dental Health Care

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Financial Menu

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy help receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For your convenience we offer a wide range of financial options in order to pay for your dental treatment.

A) **Split Payment**
Half of the total treatment is due at the preparation visit, and the second half due the day cementation of the crowns/bridges/veneers.

B) **Pay as You Go**
You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) **Prepayment in Full**
For any treatment over $2000, a prepayment bookkeeping courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

D) **Care Credit**
Care credit offers No interest financing for up to 24 months and low monthly payment options. There are no upfront costs, no prepayment penalties and no fees as long it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

Forms of Payment on Balance Due

In order to facilitate access to the very best dental possible, you choose from any of the following: cash, Visa, MasterCard, American Express, and Discover, Personal Checks or Care credit (see above).

Interest of 1.5% per month will be charges on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can.

I understand that if I become delinquent on my account, my account will be turned over to a collections agency and I will subsequently be reported to the credit bureaus. In case of total default I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child is legally responsible for the payment of services rendered.

After your dental insurance has paid for dental services rendered at Berson Dental Health Care, you may have an outstanding balance. This balance may include any deductibles, copayments, denials and non- covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization, or you may need to pay your entire balance up front.

Credit card: (check one): ☐ Visa ☐ MasterCard☐ Discover ☐Amex ☐Care Credit
Card#_____ Expiration Date: _____ CVV#:_____

Card Holder Signature: _____
Billing Address: _____ State:_____ Zip:_____

I Certify that I have read, fully understand, and accept the above financial policy.
Signature: _____ Date: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT 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 IN THE FUTURE.

_____ _____

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

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

□ Cell Phone Confirmation ¨ Text Message to my Cell Phone
□ Home Phone Confirmation ¨ Email Confirmation
□ Work Phone 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 ¨ **Any of the Above**
□ Text Message ¨ **None of the above** (opt out)
□ Email

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