WELCOME to Sleep Dentistry of Spokane!

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.
If you have any questions, please do not hesitate to ask. **Please fill out this form completely, even if updating information.**

PATIENT INFORMATION

Name _____ Nickname _____ Sex ❑ M ❑ F
Last First MI

Birthdate _____ Age _____ SS # _____ Driver's License _____ State _____

Home Phone _____ Cell Phone _____ Email: _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Employer: _____ Occupation: _____ Work Phone: _____

Emergency Contact (other than spouse) _____
Name Relationship Phone

How Did You Hear About Us? ❑Internet ❑Radio ❑Billboard ❑Phone Book ❑Newspaper ❑Community Event

❑Family/Friend _____ ❑Referring Office _____

FAMILY INFORMATION

❑ Single (own guardian) ❑ Single (dependent) ❑ Married ❑ Domestic Partnership ❑ Divorced ❑ Widowed

Spouse _____ Birthdate _____ SS # _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Father's Name: _____

Birthdate: _____ SS# _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Mother's Name: _____

Birthdate: _____ SS# _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____

INSURANCE INFORMATION

****Please Note: ProviderOne/DSHS is <u>always</u> secondary to any other coverage****

In some cases, anesthesia services are covered by Commercial Medical Insurance in addition to Dental Insurance. As a courtesy to you, we will gladly bill up to four Commercial Insurance Companies for you, two Dental and two Medical. **<u>Please provide complete information.</u>**

DENTAL INSURANCE – PLAN #1

Your relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Dependent ❑ HandiCap Dependent

DENTAL Ins Co: _____

Subscriber: _____ DOB: _____

Policy # _____ Phone: _____

Group Name # _____ Group # _____

MEDICAL INSURANCE – PLAN #1

Your relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Dependent ❑ HandiCap Dependent

MEDICAL Ins Co: _____

Subscriber: _____ DOB: _____

Policy # _____ Phone: _____

Group Name # _____ Group # _____

DENTAL INSURANCE – PLAN #2

Your relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Dependent ❑ HandiCap Dependent

DENTAL Ins Co: _____

Subscriber: _____ DOB: _____

Policy # _____ Phone: _____

Group Name # _____ Group # _____

MEDICAL INSURANCE – PLAN #2

Your relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Dependent ❑ HandiCap Dependent

MEDICAL Ins Co: _____

Subscriber: _____ DOB: _____

Policy # _____ Phone: _____

Group Name # _____ Group # _____

Payment is expected at time of service regardless of insurance. Please check your method of payment.

❑ Cash ❑ Check ❑ Visa ❑ MasterCard ❑ Discover ❑ American Express ❑ Care Credit

- *I authorize the Doctor to perform all forms of treatment, medication and therapy that may be indicated for my dental treatment. I understand that no expressed warranties of guarantees of any kind are made concerning results of procedure or treatment.*
- *I certify that I am covered by insurance and assign directly to **Sleep Dentistry of Spokane** all insurance benefits, if any, otherwise payable to me for services rendered.*
- *I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that all fees must be paid in full within 60 days of treatment regardless of insurance, unless other arrangements have been made (on approved credit only).*
- *I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.*

Patient/Guardian Signature _____ **Date** _____

Patient Name: _____ **DOB**: _____/_____/_____ **AGE**:_____

PATIENT DENTAL HISTORY

If you are seeking dental treatment with General Anesthesia, check all reasons that apply:
❑Hard to Numb ❑Dental Fear ❑Age ❑Extensive dental work ❑Other _____

Name of **Dentist**: _____ Phone #: _____ Date of last visit _____/_____/_____

❑ Are you currently in pain? If yes, where? ❑Upper Right ❑Lower Right ❑Upper Left ❑Lower Left ❑Front ❑All over
Sensitive to: ❑Hot ❑Cold ❑Sweet ❑Biting/Chewing Type of pain: ❑Dull constant ache ❑Sharp shooting pain

Do you like your smile? ❑YES ❑NO, why:_____ Do you want to save your teeth? ❑ YES ❑ NO

Do your gums ever bleed? ❑ YES ❑ NO How often do you brush your teeth? _____ How often do you floss? _____

Do you have any of the following habits? ❑ Nail Biting ❑ Ice Chewer ❑ Finger/Thumb Sucking ❑ Lip Sucking/Biting ❑ Pacifier

PATIENT MEDICAL HISTORY

Name of **Physician**: _____ Phone #: _____ Date of last visit _____/_____/_____

What are you being treated for: _____

Has your physician told you to take antibiotics before dental treatment? ❑ No ❑ YES, for: _____

Do you currently have or have you had in the past any of the following - please check all that apply:

- ☐ ADD /ADHD
- ☐ Anemia
- ☐ Arrhythmia
- ☐ Artificial Bones/Joint
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disease
- ☐ Bleed easily
- ☐ Blood Disease
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chew Tobacco
- ☐ Chronic Heartburn
- ☐ Compromised Immune System
- ☐ Congenital Heart Defect
- ☐ COPD / Emphysema
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Down Syndrome
- ☐ Drug/Alcohol Use/Abuse
- ☐ Epilepsy
- ☐ Feeding Tube
- ☐ Fever Blisters
- ☐ Gastric Bypass / Lap Band
- ☐ Glaucoma
- ☐ Headaches Severe/Frequent
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A B C
- ☐ HIV/Aids
- ☐ Hormone Therapy - Estrogen/Testosterone
- ☐ Irregular Heart Beat
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Malignant Hyperthermia
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker / Stents
- ☐ Persistent Diarrhea
- ☐ Pneumonia
- ☐ Prosthesis
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snore
- ☐ Smoker: Cigarettes / Marijuana
- ☐ Spastic Paralysis
- ☐ Stroke
- ☐ Swollen Glands
- ☐ Tracheotomy
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers/Colitis
- ☐ Wear Contacts
- ☐ Wheelchair bound

☐ Developmental Disability: _____ ☐ Other: _____

ALLERGIES - List all allergies to medications, foods or environmental, and their reactions ❑ NKDA ❑ NKFA

❑ Aspirin ❑ Ibuprofen ❑ Codeine ❑ Demerol ❑ Morphine ❑ Acetaminophen ❑ Local Anesthetic
❑ Latex ❑ Iodine ❑ Penicillin ❑ Sulfa ❑ Barbiturates ❑ Sedatives/Sleeping Pills ❑ General Anesthetic
❑ Eggs
❑Food: _____ ❑Other: _____

MEDICATIONS - List all medications & supplements and what they are for ❑ NO Medications

Name of Medication	Dosage	Taking it for

FEMALE PATIENTS

Are you of menstrual age? ❑NO ❑YES, Date last period started ____/____/____ Are you on birth control? ❑NO ❑YES

Are you pregnant? ❑NO ❑YES, Due ____/____/____ Week # _____ Are you nursing? ❑NO ❑YES

ATTESTATION & SIGNATURE: I understand that withholding any information could seriously jeopardize the safety and health of the patient. Therefore, I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

Signature _____ Relationship _____ Date _____/_____/_____

❖ **OFFICE USE ONLY** ❖ **OFFICE USE ONLY** ❖ **OFFICE USE ONLY** ❖

Height _____ Weight _____ BMI _____ ASA Class 1 2 3 4

PREVIOUS OPERATIONS / ANESTHESIA:

Type of Surgery	Date	Complications

History of Malignant Hyperthermia: ❑NO ❑**YES**

ALLERGIES - List all allergies & reactions: ❑ **NKDA** (no known drug allergies) ❑ **NKFA (**no known food allergies)

Allergy to	Reaction	Allergy to	Reaction

BLOOD / BLEEDING

KIDNEY / LIVER

BONES / JOINTS

HEART

DRUG/ALCOHOL

LUNGS

ENDOCRINE

NEUROLOGIC

GASTROINTESTINAL

PHYCHIATRIC

OTHER:

Verbally reviewed dental/medical history with patient/guardian/caregiver by Assistant/Hygienist: _____ Date _____

Reviewed by **NURSE** _____ Date _____ Reviewed by **ANESTHETIST/DENTIST** _____ Date _____

❖ **OFFICE USE ONLY** ❖ **OFFICE USE ONLY** ❖ **OFFICE USE ONLY** ❖