



<b>Patient Name:</b>		<b>Date of Birth:</b>	
<b>Name of Legal guardian (If patient is a minor):</b>			
<b>Social Security #:</b>			
<b>Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Cell Phone:</b>	<b>Email:</b>		
<b>Occupation:</b>	<b>Employer:</b>		
<b>Work Phone:</b>			
<b>Marital Status:</b>	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>
<b>Name of Spouse:</b>			<b>Number of Children:</b>
<b>Height:</b>	<b>Weight:</b>	<b>Age:</b>	<b>Referred By:</b>
<b>Previous Dentist:</b>		<b>Phone:</b>	
<b>Address:</b>			
<b>Date of your last medical examination:</b>			
<b>Name of Dental Insurance:</b>			
<b>Nearest relative not living with you?</b>			<b>Phone:</b>

Concerning fee for service dentistry, are you aware that you are responsible for all fees at the time treatment is rendered, unless prior arrangements are made?

**CONSENT FOR TREATMENT**

I hereby certify that I can read, speak, and understand the English language and hereby grant my permission to Dr. Yelena Prato and/or their associates and staff to administer to myself, my child, or my legal ward, such medications and procedures that they deem necessary, in their professional judgment, for my oral of dental health. Also, I grant my permission for them to administer local anesthetics and other medically indicated drugs or pharmaceuticals they deem necessary, to use such operative and technical procedures necessary to complete a diagnosis and/or recommended and accepted treatment has been approved. I also grant my permission to acquire and use all or any part of my records, photographs, videotapes or films which may be required for examination, diagnosis, treatment, instruction and/or scientific publication. For any purpose whatsoever, in any medium now known or in the future invented. I hereby release, discharge, and agree to hold harmless Advantage Dental Weston/Dr. Yelena Prato and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio or photographic production.

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_



**MEDICAL HISTORY**

<b>Family Physician:</b>	
<b>Address:</b>	<b>Phone:</b>
<b>In case of Emergency, notify:</b>	
<b>Relationship:</b>	<b>Phone:</b>

**Please check "Y" for yes or "N" for no:**

- | Y N  | Y N   | Y N  |
|--|---|--|
| 1. <input type="checkbox"/> <input type="checkbox"/> Medical Problem         | 14. <input type="checkbox"/> <input type="checkbox"/> Headaches             | 27. <input type="checkbox"/> <input type="checkbox"/> Major Operation      |
| 2. <input type="checkbox"/> <input type="checkbox"/> Heart Trouble           | 15. <input type="checkbox"/> <input type="checkbox"/> Anemia                | 28. <input type="checkbox"/> <input type="checkbox"/> Serious Accident     |
| 3. <input type="checkbox"/> <input type="checkbox"/> Heart Murmur            | 16. <input type="checkbox"/> <input type="checkbox"/> Fainting/Dizziness    | 29. <input type="checkbox"/> <input type="checkbox"/> HIV+                 |
| 4. <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever         | 17. <input type="checkbox"/> <input type="checkbox"/> Strokes               | 30. <input type="checkbox"/> <input type="checkbox"/> Hepatitis            |
| 5. <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure     | 18. <input type="checkbox"/> <input type="checkbox"/> Insomnia              | 31. <input type="checkbox"/> <input type="checkbox"/> Tumor/Cancer         |
| 6. <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure      | 19. <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder      | 32. <input type="checkbox"/> <input type="checkbox"/> Arthritis            |
| 7. <input type="checkbox"/> <input type="checkbox"/> Pain in Chest           | 20. <input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment | 33. <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding   |
| 8. <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath     | 21. <input type="checkbox"/> <input type="checkbox"/> Diabetes              | 34. <input type="checkbox"/> <input type="checkbox"/> Kidney Problems      |
| 9. <input type="checkbox"/> <input type="checkbox"/> Asthma/Hay Fever        | 22. <input type="checkbox"/> <input type="checkbox"/> Ulcers                | 35. <input type="checkbox"/> <input type="checkbox"/> Liver Problems       |
| 10. <input type="checkbox"/> <input type="checkbox"/> Cough                  | 23. <input type="checkbox"/> <input type="checkbox"/> Supervised Diet       | 36. <input type="checkbox"/> <input type="checkbox"/> Alcohol Dependency   |
| 11. <input type="checkbox"/> <input type="checkbox"/> Tuberculosis           | 24. <input type="checkbox"/> <input type="checkbox"/> Change in weight      | 37. <input type="checkbox"/> <input type="checkbox"/> Tobacco Dependency   |
| 12. <input type="checkbox"/> <input type="checkbox"/> Prosthetic Replacement | 25. <input type="checkbox"/> <input type="checkbox"/> Easily Fatigued       | 38. <input type="checkbox"/> <input type="checkbox"/> Drug Dependency      |
| 13. <input type="checkbox"/> <input type="checkbox"/> Communicable Disease   | 26. <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles        | 39. <input type="checkbox"/> <input type="checkbox"/> Medication Allergies |

**If yes, please explain (by number):**

**List all Medication (include aspirin, sleeping medication, sedative):**

Taking:	For:
Taking:	For:
Taking:	For:

**Women:**

- Y  N Pregnant? \_\_\_\_\_ Months?
- Y  N Miscarriage?
- Y  N Menopause/Supportive Medication?

**Do you need to be pre-medicated?**

Y  N Medication: \_\_\_\_\_ For: \_\_\_\_\_

**Are there any medical concerns or lifestyle situations that you would like to discuss?**

Y  N Explain: \_\_\_\_\_

**Patient Signature (or Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name (or Legal Guardian):** \_\_\_\_\_



**NEW PATIENT DENTAL HISTORY**

The following are intended to assist us in providing you with the most comprehensive and preventative dental care according to your present dental condition and your expectations of high quality personal dental care. Please answer each question by placing a check on “Y” for yes or “N” for no. Thank you.

1. When was your most recent prophylaxis? (teeth cleaning)  
Over 2 years ago                       Over 1 year ago                       within the last year
  
2. Are you presently in any dental pain?
  
3. Have you ever had orthodontic treatment?
  
4. Do you have any growths or swellings in your mouth?
  
5. Do your gums bleed when brushing your mouth?
  
6. Have you ever had a bad reaction to dental anesthetic?
  
7. Are you aware of clenching your teeth during daytime hours?
  
8. Have you ever been told you grind your teeth during sleep?
  
9. Are you aware of your jaw clicking or popping while eating or yawning?
  
10. Do you have an unpleasant taste or odor in your mouth?

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_



**APPOINTMENT CANCELLATION POLICY**

Dear Patient,

Please be advised that Advantage Dental Weston requires 24-hour notice to reschedule your appointment. If you fail to cancel your appointment within a 24-hour time, you will be billed a \$50.00 fee.

Please contact our office immediately if you should have to cancel or reschedule your appointment.

Please sign below to indicate that you have read and understood this policy.

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_



**RESPONSIBILITIES AND PAYMENT OPTIONS**

We are committed to providing the best dental care possible. If you have dental insurance, we will gladly help you understand and maximize your allowable benefits. In case you don't have dental insurance, payment for services is due at the time services are rendered. We accept cash, checks, credit cards, and debit cards. We can also offer financing options through Care Credit.

Please be informed there is a \$25.00 charge for all returned checks. Balances older than 30 days will be subject to additional charges.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. You are responsible for your deductible and any portion your insurance does not pay. "Usual, Customary and Reasonable" charges are determined by each individual insurance company. "UCR is determined by both geographical region and the contract between your employer and the insurance company.
3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover.
4. Balances, which have not been paid within 90 days, will be sent over to a collection agency. Should this account become a collection matter, the patient or legal guardian assumes all cost of collection, including, but not limited to the court costs, interest and legal fees.

If you have questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help.

I have truly read and understand that I am responsible for all cost of Dental Treatment.

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_



**HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided with **YELENA PRATO-GUIA DMD, INC.**, “Notice of Privacy Practices”, and I am giving my consent for the use and disclosure of Protect Health Information as required and/or permitted by law.

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_

**EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM**

**Purpose:** This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **YELENA PRATO-GUIA DMD, INC., (YPG)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **YPG** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **YPG** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **YPG** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

**PATIENT ACKNOWLEDGMENT & AGREEMENT**

**My Consented Email Address is:** \_\_\_\_\_

**My Consented Mobile Number for Text Messaging is:** \_\_\_\_\_

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_

**IN CASE OF EMERGENCY:** please call 911 or proceed to the nearest emergency room. **Do not use this way of communication for that purpose**



**EPWORTH SLEEPINESS SCALE**

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

**It is important that you circle a number (0 to 3) for EACH situation.**

**SITUATION**

**CHANCE OF DOZING**

Sitting and reading

Watching television

Sitting inactive in a public place (at the movies)

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 (with no alcohol)

In a car, while stopped in traffic

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_



**STOP-BANG SLEEP APNEA QUESTIONNAIRE**

**Chung F et al Anesthesiology 2008 and BJA 2012**

As part of our commitment to your overall health and well-being, we kindly ask you to complete the STOP-BANG Sleep Apnea Questionnaire. This questionnaire helps us assess your risk factors for sleep apnea, a condition that can impact both your dental health and general wellness.

**STOP**

Do you <b>SNORE</b> loudly (louder than talking or loud enough to be heard through closed doors)?	
Do you often feel <b>TIRED</b> , fatigued, or sleepy during daytime?	
Has anyone <b>OBSERVED</b> you stop breathing during your sleep?	
Do you have or are you being treated for high blood <b>PRESSURE</b> ?	

**BANG**

<b>BMI</b> more than 35kg/m <sup>2</sup> ?	
<b>AGE</b> over 50 years old?	
<b>NECK</b> circumference > 16 inches (40 cm)	
<b>GENDER</b> : Male?	

**Patient Signature** (or Legal Guardian): \_\_\_\_\_ **Date**: \_\_\_\_\_

**Patient Name** (or Legal Guardian): \_\_\_\_\_