Briggs Family & Cosmetic Dentistry

PATIENT REGISTRATION

Patient Information

Date _____

Patient's Name _____ Preferred Name _____
Last First Middle

Address _____ Birth Date _____

City _____ State _____ Zip Code _____ Social Security # _____

Home Phone # _____ Cell # _____ Work # _____

E-Mail Address _____

Gender: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Who may we thank for referring you to our office? _____

Responsible Party Information (if someone other than patient)

Name _____
Last First Middle

Address _____ Birth-date _____

City, State, Zip _____ Social Security # _____

Home Phone # _____ Cell # _____ Work # _____

Relationship to Patient _____

We ask that you please notify us at least 48 hours in advance if needing to change or cancel any appointments – or a $50.00 charge will be assessed to your account.

Insurance Information

Name of Primary Insured _____ Relationship to Patient □Self □Spouse □Child □Other

Insured SS# or Alternate ID# _____ Insured Birth Date _____

Name of Insurance Co. _____ Employer _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone # _____ Phone # _____

Name of Secondary Insured _____ Relationship to Patient □Self □Spouse □Child □Other

Insured Social Security _____ Insured Birth Date _____

Name of Insurance Co. _____ Employer _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone # _____ Phone # _____

Time 10:44 AM

Briggs Family And Cosmetic Dentistry

MEDICAL HISTORY

Date 2/9/2017

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body.

Health problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes

Have you recently been hospitalized or seen at urgent care? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, and/or supplements? If so, please list: Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Do you routinely drink soda, energy drinks, or orange juice? Yes No

Do you use or have you ever used tobacco? Yes No

Do you use or have you used controlled substances? Yes No

Have you been told to premedicate prior to dental treatment? If so, list the physician and why Yes No If yes

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

other? Yes No If yes

* WOMEN ONLY

- Pregnant/ Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?
- Hormone Replacement Therapy?
- Perimenopausal/ Menopausal?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Allergies	Yes No	Alzheimer's Disease	Yes No	Anaphylaxis	Yes No
Anemia	Yes No	Angina	Yes No	Arthritis	Yes No	Artificial Heart Valve	Yes No
Artificial Joint	Yes No	Asthma	Yes No	Blood Disease	Yes No	Breathing Problems	Yes No
Cancer	Yes No	Chemotherapy	Yes No	Chest Pain	Yes No	Cold Sores	Yes No
Congenital Heart Disorder	Yes No	Convulsions	Yes No	Diabetes	Yes No	Drug Addiction	Yes No
Eating Disorder	Yes No	Easily Winded	Yes No	Emphysema	Yes No	Epilepsy or Seizures	Yes No
Excessive Bleeding	Yes No	Excessive Thirst	Yes No	Fainting/ Dizziness	Yes No	Frequent Cough	Yes No
Frequent Headaches	Yes No	Glaucoma	Yes No	Hard of Hearing/Hearing Aids	Yes No	Hay Fever	Yes No
Heart Attack/Failure	Yes No	Heart Murmur	Yes No	Heart Pacemaker	Yes No	Heart Trouble/Disease	Yes No
Hemophilia	Yes No	Hepatitis A	Yes No	Hepatitis B or C	Yes No	Herpes (cold sores)	Yes No
High Blood Pressure	Yes No	High Cholesterol	Yes No	Hives or Rash	Yes No	Hypoglycemia	Yes No
Low Blood Pressure	Yes No	Lung Disease	Yes No	Mitral Valve Prolapse	Yes No	Multiple Sclerosis	Yes No
Osteopenia/Osteoporosis	Yes No	Pain in Jaw Joints	Yes No	Parathyroid Disease	Yes No	Psychiatric Care	Yes No
Radiation Treatment	Yes No	Recent Weight Loss	Yes No	Rheumatic Fever	Yes No	Scarlett Fever	Yes No
Shingles/ Chicken Pox	Yes No	Sinus Trouble	Yes No	Sjogren's Syndrome	Yes No	Sleep Apnea	Yes No
Stomach/Intestinal Disease	Yes No	Stroke	Yes No	Swelling of Limbs	Yes No	Thyroid Disease	Yes No
Tonsilitis	Yes No	Tuberculosis	Yes No	Tumors or Growths	Yes No	Ulcers	Yes No
Venereal Disease	Yes No						

Have you had any serious illness not listed? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Briggs Family & Cosmetic Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been informed of the September 2013 Revision

I_____ have received/read a copy of this Office's Notice of Privacy Practices.

I give the following permission to Briggs Family Dentistry:

I give this office permission to speak with: _____ regarding my account billing, dental health and/or treatment needs. (Excludes medical providers)

I give this office permission to correspond via text and email:

_____ _____
Cell Number Email Address

_____
Signature of Patient

_____ _____
Printed Name of Patient Date

- Office Use Only -

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practice, but acknowledgement could not be obtain because:

____ Individual to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

Briggs Family & Cosmetic Dentistry
6920 E. Shea Blvd. #201
Scottsdale, AZ 85254

Sleep Disorders Breathing Screening

Patient Name: _____ ***Date:***_____
DOB: _____ Gender: M F

Have you been told you snore?	Yes _____	No _____
Do you ever choke or gasp while you sleep?	Yes _____	No _____
Do you feel tired, fatigued or sleepy during the day?	Yes _____	No _____
Do you experience chronic nasal congestion?	Yes _____	No _____
Do you have high blood pressure?	Yes _____	No _____
Do you have acid reflux/GERD?	Yes _____	No _____
Have you had an overnight sleep study?	Yes _____	No _____
If yes, approximate date _____		
Do you have a CPAP?	Yes _____	No _____
If yes, do you use your CPAP nightly? ____ Yes ____No		

<u>For Staff Use</u>

Physical Exam: (indicate all that are present)
_____ Large Tonsils
_____ Scalloped/Large Tongue
_____ Narrow Palate

Mallampati Score: _____

Additional Notes:_____
_____

____Patient appears to have minimal risk of Sleep Disorders Breathing ***Staff Initials:***_____

<u>Recommended Next Steps</u>

___ Diagnostic Sleep Test ___ Oral Appliance Consultation ___ Referral to Specialist
___ Educational Brochures given to patient
___ Informational Resources Handout given to patient
___ Gave patient information on Snore Lab app for phone

<u>Notes:</u>