PATIENT INFORMATION

Name:_____ _____ **I prefer to be called:**_____

Home Phone:_____ **Cell Phone:**_____ **E-Mail:**_____

Home Address:_____
STREET CITY STATE ZIP CODE

Birth Date:_____ **Patient's Age:** _____ **Sex: M / F** **Social Security #:**_____

Place of Employment:_____ **Telephone:**_____

Business Address:_____
STREET CITY STATE ZIP CODE

Marital Status: _____Single _____Married _____Separated _____Widowed _____Divorced

Spouse's Name:_____ **Spouse's DOB:**_____ **Spouse's SSN#:**_____

Spouse Employed By:_____**Telephone:**_____

How did you hear about our office (please circle)? **Friend or relative** **Insurance Company** **Our Website** **Drove by the office**

Search Engine (google,etc.) **Advertisement** **Other:**_____

If referred, who may we thank?_____

INSURANCE INFORMATION

(please provide a copy of your insurance card)

Policy Holder:_____**Insurance Company:**_____

Policy Number:_____ **Employer:** _____

INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT

All of the above information is correct to the best of my knowledge. I authorize use of this form on all of my insurance submissions and I authorize the release of information to my insurance company(s). I understand that I am responsible for my bill. I authorize Crawfordsville Family Dentistry and the office of Dr. Scott Frey to act as my agent in helping me to obtain payment from my insurance company. I authorize payment to Crawfordsville Family Dentistry / Dr. Scott Frey. I permit a copy of this authorization to be used in place of the original. I give this dental office, its employees, and/or other agents express prior consent to contact me at any/all phone numbers (by phone call or text message) and e-mail addresses, for the purpose of appointment reminders, treatment, insurance or payment.

I hereby authorize Dr. Frey or his designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Frey to perform all recommended treatment which has been mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications to make my visit more comfortable. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I have read, understood and agree to the above information.

_____

PATIENT SIGNATURE **DATE**

MEDICAL HISTORY

Name of Family Doctor:_____ **Telephone:**_____

1. Are you under medical treatment now? If so, for what condition(s)? _____

_____

2. Are you currently taking any medications? If so, please list: _____

_____

_____

3. Are you allergic to any medications? If so, please list:_____

4. Do you use tobacco in any form? If yes, how much?_____

5. (Women) are you pregnant? If yes, what is your due date?_____

6. Have you ever had trouble with bleeding after surgery? _____**Yes** _____**No**

7. Do you have or have you ever had any of the following conditions? (please check all that apply)

___ **High Blood Pressure**	___ **Kidney or Liver Disease**	___ **Anemia**	___ **Psychiatric Treatment**
___ **Prosthetic Heart Valve**	___ **Infectious Disease (TB, HIV, AIDS)**	___ **Diabetes**	___ **Cancer**
___ **Bacterial Endocarditis**	___ **Any Blood Diseases**	___ **Stroke**	___ **Radiation Treatment**
___ **Cardiac Valvulitis**	___ **Asthma**	___ **Seizures**	___ **Chemotherapy**
___ **Congenital Heart Disease**	___ **Artificial Joints or Limbs**	___ **Arthritis**	___ **Acid Reflux**
___ **Latex Allergy**	___**Sleep Apnea**	___ **Other:** _____	

8. Do you require antibiotic pre-medication for your dental work? If yes, what condition?_____

9. Is there any other information that we should know about your health? Please describe: _____

_____

10. If necessary, may we contact your medical doctor regarding your care? _____**Yes** _____**No**

11. Do you wish to talk to the dentist privately about any problems or concerns? _____**Yes** _____**No**

12. What is your pharmacy of choice if we need to call in any prescriptions? _____

DENTAL HISTORY

1. What is the reason for your for your visit today?_____

2. What is the best description of your past dental treatment? Please check one of the following:

___ At Least 2 Visits A Year ___ At Least Once A Year ___ Only When I Have A Problem ___ About Once Every 2 – 3 Years

3. If you have ever had a bad dental experience, please describe:_____

4. If you are nervous about dental treatment, please explain:_____

5. Would you be interested in taking a pill to relax you for dental treatment (oral sedation)? ____Yes ____No

6. Have you ever had an adverse reaction to dental anesthetic? If yes, please describe:_____

7. Do you have any broken or missing teeth that you would like to have fixed or replaced? ___Yes ___No

8. Is there anything you would like to change about your teeth or smile? If so, what? _____

_____

9. Do you have any upcoming event or circumstances (such as weddings, major surgeries, losing insurance, etc.)

that we should or need to know about? If so, what and when?_____

_____

10. Do you snore? _____Yes _____No

11. Are you affected by someone who snores? _____Yes _____No

12. Have you ever been diagnosed with Sleep Apnea? _____Yes _____No

If yes, do you use your CPAP machine all night, every night? _____Yes _____No

If No, why not?_____

Obstructive sleep apnea is a potentially fatal sleep related breathing disorder that is frequently undiagnosed. **Snoring** is the most common symptom of sleep apnea as well as feeling extremely tired throughout the day. People with sleep apnea may snore loudly and stop breathing for short periods of time throughout the night. Oftentimes these patients will wake up in the morning feeling tired and unrefreshed. Sleep apnea patients have a much higher risk of ***stroke, heart attack, congestive heart failure and hypertension***. As a member of the American Academy of Dental Sleep Medicine we are able to work directly with your medical doctor to help determine the best course of treatment if you have a sleep related breathing disorder. Please fill out the Sleep Screening Form on the following page to help us determine if any additional testing is required for you. Your dental health and your overall health are our top priorities! Thank you.

****

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that this information is necessary to provide me with dental care in a safe and efficient manner.

PATIENT SIGNATURE **DATE** **DENTIST SIGNATURE** **DATE**

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name	Middle Initial	Last Name

Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender: **Male** ◯ **Female** ◯
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score ☐

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
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 lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score ☐

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

Assign points for each of the first three responses

☐
☐
☐

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	☐