Surf City Dentist
Ken Yabuki, D.D.S.
Jeff Coleman, D.D.S.
www.surfcitydentist.com

DENTAL HISTORY

Name:_____ **Today's Date** _____
Appt. Date _____

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care.
All information is completely confidential.

☐ **Fragrance Free** ☐ **Out of Network Verified** **Referred By:** _____

Name _____ Date of Birth _____ Email _____
Address _____ City _____ State _____ Zip _____

What is the reason for your visit today? _____
Insured (if not pt) _____ Employer _____ DOB _____ SS# _____
Insurance Co. _____ Group # _____ Member ID _____
Address _____ City _____ State _____ Zip _____
Previous Dentist Name & Number _____
Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

How frequently do you have a dental examination? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No
What other dental aids do you use (Interplak, toothpick, Waterpik, etc.)? _____
Do you have any dental problems now? ☐ Yes ☐ No
If yes, please describe: _____

Are you seeking information or interested in hearing about any of the following:

Teeth Whitening?	☐ **Yes**	☐ **No**
Cosmetic Dentistry (veneers, full mouth reconstruction, etc)?	☐ **Yes**	☐ **No**
Restorative treatment options (Crowns, Implants, Dentures, etc.)?	☐ **Yes**	☐ **No**
Removable treatment options (Implant supported dentures, All-on-Four, etc.)?	☐ **Yes**	☐ **No**
Snoring and Obstructive Sleep Apnea treatment options?	☐ **Yes**	☐ **No**
Orthodontic Treatment (braces, Invisalign, etc)?	☐ **Yes**	☐ **No**

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Have your parents experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth?	☐ Yes	☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or other tobacco products?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral surgery?	☐ Yes	☐ No
Periodontal surgery?	☐ Yes	☐ No
Your teeth ground or bite adjusted?	☐ Yes	☐ No
An occlusal guard, night guard or mouth guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

If yes, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain (joint, ear, side of face)?	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Headaches, neck aches, or shoulder aches?	☐ Yes	☐ No
Sore muscles (neck, shoulders)?	☐ Yes	☐ No
Are you satisfied with your teeth's appearance?	☐ Yes	☐ No
Would you like to keep all of your teeth all of your life?	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe _____

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MEDICAL HISTORY

Todays Date _____

Name _____ Marital Status _____ Sex _____ Date of Birth _____
Email _____
Address _____ Home/Cell Phone _____
Street City Zip Work Phone _____
Former Dentist _____ How Long? _____
Name Phone
Physician _____
Name Address Phone
Referred By: _____ Reason: _____
Employed By: _____ Occupation: _____

1. Have you had any medical care or surgeries within the past two years?..... ☐ Yes ☐ No
   Describe _____
2. Are you currently **taking any medication, drugs, pills, or herbal remedies**, including regular dosages of aspirin? ☐ Yes ☐ No
   If Yes, please list:_____
   _____
3. Do you use Tobacco/Nicotine in any form? ☐ Smoke ☐ Chewing ☐ E-cigs/Vape ☐ Other Form ☐ Yes ☐ No
4. Have you ever taken bone loss prevention drugs such as **Fosamax, Actonel, Boniva,** or other similar drugs?..... ☐ Yes ☐ No
5. Have you **EVER had an ADVERSE or ALLERGIC reaction** to any substance or medication?..... ☐ Yes ☐ No
   If Yes, please specify _____
6. Have you ever been diagnosed and/or treated for Sleep Apnea? ☐ Yes ☐ No
7. Do you have any of the following symptoms? ☐ Daytime Sleepiness ☐ Snoring ☐ Waking Gasping for Air
8. Indicate **which** of the following **you have had**, or **have at present**. Check "Yes" or "No" to each item:

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Hepatitis A, B, C	☐ Yes	☐ No
			Thyroid Problems	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Congenital Heart Problems	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Difficulty Swallowing	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Hemophilia/Bleeding Disorder	☐ Yes	☐ No
Pacemaker/Defibrillator	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Cortisone Medication	☐ Yes	☐ No	Hay Fever/Allergy/Hives	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Latex Sensitivity/Allergy	☐ Yes	☐ No	Alzheimers or Dementia	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
			Radiation Therapy	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Arthritis/Joint Pain	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No			

9. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
   If Yes, please specify _____
10. Women: Are you Pregnant or think you could be pregnant? ☐ Yes, ___ Months ☐ No Nursing? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient/Guardian Signature _____ Date _____
Comments:

Provider Signature _____ Date _____

OFFICE FINANCIAL POLICY

Thank you for choosing us as your family's dental health care provider. We are committed to providing your family with ideal treatment. It is our goal for patients to clearly understand their treatment needs and financial responsibilities. The following is a statement of our financial policy which we require you read, agree to, and sign; prior to any treatment. This financial policy applies to all services rendered by the doctor or dental hygienists.

In order to avoid any misunderstandings, we would like to make you aware of our financial policy:

- Due to the high demand for appointments ***a <u>48-hour business day notice</u> is required to cancel any office appointment.*** *This must be done with a member of our staff and not by text, email or answering machine. Failure to give our office 48-hour business day notice may result in a minimum charge of $75.00.*
- Payment is expected in full for each visit.
- We accept payment in cash, check, or credit card (Master Card/Visa/Discover)
- We also offer a financing plan called "***Care Credit".***
- All other financial arrangements must be made in writing.
- There will be a charge for returned checks.

If you have Dental Insurance

It is our policy that the patient, rather than the insurance company, is responsible for the complete payment of our services. Your insurance policy is a contract between you, your employer, and your insurance company. We are not party to that contract. Our relationship is with you, not your insurance company. As a courtesy to our patients, we will accept assignment of insurance benefits. All patients with insurance coverage are responsible for payment of non-covered services, any deductible amount not previously met and any co-payment due, at the time services are rendered. We will bill your insurance when you have supplied us with all of the necessary information required to process your claim.

In order to avoid any misunderstandings, we would like to make you aware of our insurance policy

- If your insurance company has not paid our office within 45 days from the time of service, you will be required to pay the balance in full by one of the payment options stated above. Any balance over 60 days will accrue a 1.5% finance charge and any account past due over 90 days is subject to legal proceedings. All necessary collection charges will be the responsibility of the patient.
- We are **not an HMO provider**. We ask that the patient be aware of their plan and its coverage **prior** to their appointment.
- We are a Delta Dental PPO and Premiere provider but we are considered an **out-of-network** provider with all other insurance companies.
- Our estimate of the insurance coverage is not a guarantee of what the insurance company will pay.

If there are any questions concerning these policies, please ask.

I,_____/_____ have read and understand the financial policy.
Signature **Date**

(Print Name)_____ S.S.#_____-_____-_____

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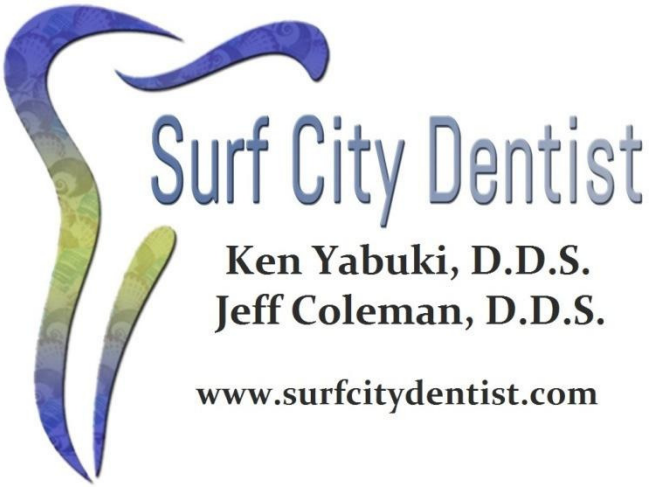

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Heath Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I _____, acknowledge I have received from this office:

1. A copy of the Dental Materials Fact Sheet; and
2. Notice of Privacy Practices.

_____ _____

Patient Signature or Personal Representative Date

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient.

_____
_____
_____
_____

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SLEEP EVALUATION

Todays Date _____

Name _____

Date of Birth _____ Gender: M____ F____ Height:_____ Weight:_____

Please check any of the following you may have:		
☐ Diabetes	☐ Bruxims (teeth grinding)	☐ Erectile Dysfunction
☐ Stroke	☐ Obese (BMI >30)	☐ Frequent Urination at Night
☐ Depression	☐ Hypertension (High Blood Pressure)	☐ Morning Headaches
☐ Gerd (Acid Reflux)	☐ Snoring	☐ Waking, Choking, Gasping for Air

Please check YES of NO to the following questions:		
1. Do you snore or have you been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered YES to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never Doze Off	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
How likely are you to get sleepy or doze off during the following activities:				
1. While sitting and reading?	☐ 0	☐ 1	☐ 2	☐ 3
2. While watching TV?	☐ 0	☐ 1	☐ 2	☐ 3
3. While sitting inactive in a public place?	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break?	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon?	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking to someone?	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after lunch without alcohol?	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car while stopped for a few minutes at a traffic light?	☐ 0	☐ 1	☐ 2	☐ 3
			Total Score: ____	

0-5 = Normal Daytime Sleepiness
6-10 = Higher Normal Daytime Sleepiness
11-15 = Mild to Moderate Risk
16-Higher = Severe Risk

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP (or any other apnea/snoring device)?	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you aware of clenching or grinding your teeth?	☐ YES	☐ NO

Patient/Guardian Signature _____ Date _____
Comments:

Provider Signature _____ Date _____