South Bay
DENTISTRY

JOSHUA BELOF, DMD

Patient Information Form

Name:_____ Nickname:_____
Person is: O Patient O Policy Holder O Responsible Party

Address:_____City:_____State:_____Zip_____
Home phone:_____ Work Phone:_____
Cell Phone: _____ Email: _____
Date of Birth:_____ Social Security Number: _____

How did you hear about us? Mailer Internet Family/Friend Drive-By Other:_____
If you were referred by a current patient, whom may we thank?
_____

For those with insurance, and if different from above:
Policy Holder Name, as on the card: _____
Address:_____
Date of Birth: _____ Social Security Number: _____
Employer: _____
Insurance Company:
_____
Address for Claims:
_____
Phone Number:
_____
Member ID: _____ Group #: _____

Emergency Contact Information

Full Name: _____ Relationship: _____
Contact Phone: _____ Alternate Phone: _____

DENTAL HISTORY

Reason for today's visit?_____

Name of your last dentist?_____ Date of your last dental visit:?_____

What was done at your last dental visit?_____

Why did you leave your last dentist:? _____

Out of all the offices locally, what made you choose ours?_____

_____

Has anything kept you from seeing a dentist regularly or getting needed dental work done?

_____

Do you clench or grind your teeth? Yes No Maybe

Are your teeth sensitive to hot/cold? Yes No Sometimes

Are you experiencing pain or discomfort in your teeth? If yes, explain: _____

_____

Are your gums irritated, tender or swollen? If yes, explain: _____

Do your gums bleed? If yes, explain: _____

On average, how many times per week do you floss? 7 6 5 4 3 2 1 rarely never

Have you ever been told you have "gum disease" or need "deep cleanings"? Yes No

Which type of toothbrush do you use? Manual Electric Brand_____

Do you suffer from headaches? If yes, how many times per month?_____

Are you missing any teeth? _____

Do you have a dry mouth? Yes No

In the past, how frequently did you have your preventive dental visits (cleanings)?

__3 months __ 6 months __ 12 months __13+months

How important is it to you to have optimal oral health? Not very 1 2 3 4 5 Very

How important is "preventive" dentistry to you? Not very 1 2 3 4 5 Very

How important is it to you to improve your smile? Not very 1 2 3 4 5 Very

Do you have any old filling or previous dental treatment that is no longer satisfactory to you? If yes, please explain _____

Please use the space below and let us know any other concerns you may have, including how we can make your visits meet your needs:

_____

_____

Please check which condition/procedures you would like to learn more about:

__crowded teeth	__spaced teeth	__improper bite	__implants
__grinding/clenching	__replace silver fillings	__one visit crowns	__sealants
__gum disease	__gum recession	__porcelain veneers	__dentures
__wisdom teeth	__whiten teeth	__partial dentures	

Medical History

Patient Name:_____ **Birth Date:**_____

Although dentistry primarily treats the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an impact on the dentistry you will receive.

Please list all medications you are taking, both over the counter and prescription

Name:	For:

Do you have any known allergies to any of the following?

☐Penicillin ☐Codeine ☐Aspirin ☐Latex ☐Acrylic ☐Metal Other_____

Women: Are you

Pregnant/trying to get pregnant? ☐Yes ☐ No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐ Yes ☐ No

General:

Do you use tobacco? ☐Yes ☐No How much per day?_____

Have you ever had to take antibiotics before receiving routine dental care? ☐ Yes ☐No Why?_____

Have you ever taken a bisphosonate medicine? (common ones are Fosamax, Actonel, Boniva) ☐ Yes ☐ No

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

Y N	Y N	Y N	Y N
☐ ☐AIDS/HIV Positive	☐ ☐Cortisone Medicine	☐ ☐High Blood Pressure	☐ ☐Scarlet Fever
☐ ☐Alzheimer's Disease	☐ ☐Diabetes	☐ ☐Hives Or Rash	☐ ☐Shingles
☐ ☐Anaphylaxis	☐ ☐Drug Addiction	☐ ☐Hypoglycemia	☐ ☐Sickle Cell Disease
☐ ☐Angina	☐ ☐Easily Winded	☐ ☐Irregular Heartbeat	☐ ☐Sinus Trouble
☐ ☐Arthritis/Gout	☐ ☐Emphysema	☐ ☐Kidney Problems	☐ ☐Spina Bifida
☐ ☐Artificial Heart Valve	☐ ☐Epilepsy/Seizures	☐ ☐Leukemia	☐ ☐Stomach/Intestinal Disease
☐ ☐Artificial Joint	☐ ☐Excessive Bleeding	☐ ☐Liver Disease	☐ ☐Stroke
☐ ☐Asthma	☐ ☐Excessive Thirst	☐ ☐Low Blood Pressure	☐ ☐Swelling Of Limbs
☐ ☐Blood Disease	☐ ☐Fainting Spells/Dizziness	☐ ☐Lund Disease	☐ ☐Thyroid Disease
☐ ☐Breathing Problems	☐ ☐Frequent Headaches	☐ ☐Mitral Valve Prolapse	☐ ☐Tonsillitis
☐ ☐Bruise Easily	☐ ☐Heart Attack/Failure	☐ ☐Parathyroid Disease	☐ ☐Tuberculosis
☐ ☐Cancer	☐ ☐Heart Murmur	☐ ☐Psychiatric Care	☐ ☐Tumors or growths
☐ ☐Chemotherapy	☐ ☐Heart Pace Maker	☐ ☐Radiation Treatments	☐ ☐Ulcers
☐ ☐Chest Pains	☐ ☐Heart Trouble/Disease	☐ ☐Recent Weight Loss	☐ ☐Yellow Jaundice
☐ ☐Cold sores/Fever blisters	☐ ☐Hemophilia	☐ ☐Renal Dialysis	
☐ ☐Congenital Heart Disorder	☐ ☐Hepatitis A	☐ ☐Rheumatic Fever	
☐ ☐Convulsions	☐ ☐Hepatitis B or C	☐ ☐Rheumatism	

Have you ever had any serious illness not listed above? ☐Yes ☐ No If yes, Please Explain:_____

DoctorsComments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can 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_____ Date_____

DOCTORS SIGNATURE_____ Date_____

Dental Sleep Screening Questionnaire

Name _____ **Date**_____

How likely are you to doze off in the following situations?

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Sitting and reading ____

Watching TV ____

Sitting inactive in a public place (e.g. theater or a meeting) ____

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 a lunch without alcohol ____

In a car, while stopped for a few minutes in traffic ____

Add your scores up Total _____

Do you feel you get poor quality sleep? Yes No

Has anyone noticed if you quit breathing during your sleep? Yes No

Do you ever wake up in the night snorting or gasping for air? Yes No

Have you ever been diagnosed with sleep apnea? Yes No

Do you have a CPAP machine? Yes No

If yes, on average how many nights/wk do you wear it? ____ nights

What % of the night do you wear it? ____ % of the night

Do you snore? Yes No

Has anyone ever told you that you snore? Yes No

Are you interested in hearing more about dental appliances which can eliminate snoring for either you or your bed partner? Yes No

FINANCIAL AND APPOINTMENT POLICIES

Thank you for choosing our office for your dental needs. Our practice offers various payment and financial options to meet our patient's needs. As a courtesy, we will gladly assign payments for dental treatment from your insurance company directly to our office. Dental insurance is a contract between you, your employer or plan sponsor, and the insurance company. These contracts vary widely, therefore, we will do our best to estimate the portion your insurance company will pay toward your treatment and process any claims needed. **We cannot guarantee payment from your insurance company and your balance may be different than our estimate. In the event that your insurance company refuses to pay all or a portion of your claim, you will be responsible for payment for your dental treatment.**

Initials

_____ 1. **Dr. Belof is not contracted with any dental insurance company as an in network provider**. However, most PPO insurances plans will still pay this office.

_____ 2. You agree that the charges you incur here are **your responsibility regardless of what your insurance company pays or does not pay** toward your treatment.

_____ 3. **You agree to pay your bill in full if your insurance company had not paid, or underpays for your treatment**. You understand that your insurance company may ask for additional information and we will provide this information upon request. If for any reason there is an overpayment on your account, a refund check, or credit on your credit card, will be sent.

_____ 4. **You agree that we are not responsible for knowing the various scenarios in which your insurance does not pay services.** Such scenarios include preexisting conditions, waiting periods, x-rays which can only be paid on every so often, less costly alternatives, required pre-authorizations, etc. Your insurance can use these and other reasons to avoid paying your claim. We will try to provide you with as much information as possible; however, we will not be responsible for knowing the various intricacies of your particular insurance contract. You will be responsible for knowing your benefits and informing us of any changes.

_____ 5. **Furthermore, we reserve the right to charge a fee for appointments missed without giving at least 48 hours notice, as this time could have been used for other patients.**

I have read and agreed to the above payment policy

Patient Signature: _____ Date _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

I give permission to disclose details of my account, chart, and conditions to the following people.
(The most frequently listed person is the spouse).

Name_____ Relationship _____

Name_____ Relationship_____

Name_____ Relationship_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____