G. BROOKS HANEY DDS – NEW PATIENT FORMS

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Date _____

Last Name _____First Name _____M. I. _____Prefer to be called by _____

Birth date _____ Age _____ Male _____ Female _____

If minor, parent/guardian names _____ Home phone _____ Work phone _____

Cell Phone _____ Fax _____ Email address _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed

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

Person to contact for Emergency _____ Phone numbers _____ _____

Emergency Contact Address _____ City _____ St _____ Zip _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑NOT covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group # _____

Employer Name _____ Insured's Name _____ Date of Birth _____

Relationship to patient _____ Insured's ID Number _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

For Minors: School _____ Grade _____ SS# _____

Person Financially Responsible For Account _____Relationship to Patient _____

Address _____ City _____State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

HEALTH HISTORY

IN ORDER TO PROVIDE THE BEST CARE POSSIBLE FOR YOUR PARTICULAR NEEDS, PLEASE FILL THIS FORM OUT CAREFULLY.

NAME: _____BIRTHDATE:_____AGE:_____

WHAT IS YOUR MAIN REASON FOR SEEKING DENTAL TREATMENT?

_____

1. Physicians Name _____ Phone _____
   Have you had any medical care within the last 3 years? YES _____ NO _____
   If yes, describe _____

2. Have you taken any medications or drugs during the past 2 years? YES _____ NO _____

3. Are you currently taking any medications, drugs, herbal remedies, or pills (such as regular dosages of aspirin)? YES _____NO ____

   If yes, please list drug names, dosages, and frequency _____

   _____

4. Have you ever taken prescription medications for weight loss (diet pills)? YES _____ NO _____

   If yes, did you take any of the following (check if yes): ❑ Fen-Phen ❑ Pondimen ❑ Redux ❑ other

   If yes to any of the above, did you have a medical exam for heart tissues? YES_____ NO _____

5. Have you ever taken bone loss prevention medication such as Fosomax, Boniva, Actonel, or others? YES _____ NO _____

6. Have you been hospitalized during the past 5 years? Yes _____ No _____

7. Do you use tobacco in any form? If yes, how much _____	YES	NO
8. Do you smoke or use chewing tobacco?	YES	NO
9. Are you aware of having an allergic (adverse) reaction to any substance or medication?	YES	NO (LIST ON PAGE 4)
10. Have you lost or gained more than 10 pounds in the past yr?	YES	NO
11. Are you pregnant or do you think that you could be pregnant?	YES	NO Months pregnant: _____
Nursing?	YES	NO
12. Do you use birth control prescriptions?	YES	NO

Do you have or have you had any of the following? (Please **CIRCLE** any that apply)

Heart ailment or Angina – Heart Surgery or Attack	YES	NO
Chest Pain	YES	NO
Heart murmur, Mitral Valve Prolapse, Heart Defect	YES	NO
Rheumatic fever or Rheumatic heart disease	YES	NO
Artificial Heart Valve	YES	NO
Congenital Heart Disease	YES	NO
High or Low blood pressure	YES	NO

HEALTH HISTORY CONTINUED:

Pacemaker	YES	NO
Cortisone Medication	YES	NO
Swollen Ankles	YES	NO
Arthritis/Rheumatism	YES	NO
Stroke	YES	NO
Diet (Restricted or Special)	YES	NO
Artificial Joints (knee, hip, etc.)	YES	NO
Kidney Disease	YES	NO
Ulcers	YES	NO
Diabetes	YES	NO
Thyroid Problems	YES	NO
Glaucoma	YES	NO
Contact Lenses	YES	NO
Chronic cough	YES	NO
Emphysema	YES	NO
Asthma	YES	NO
Tuberculosis or other Lung problems	YES	NO
Hay Fever/Allergy/Hives	YES	NO
Latex Sensitivity	YES	NO
Sinus Trouble	YES	NO
Radiation Therapy	YES	NO
Chemotherapy	YES	NO
Tumors or Cancer	YES	NO
Hepatitis A B C (circle)	YES	NO
Liver Disease/Yellow Jaundice	YES	NO
Venereal Disease	YES	NO
Alcoholism	YES	NO
Blood Transfusion	YES	NO
Hemophilia	YES	NO
Sickle Cell Disease	YES	NO
Bruise Easily	YES	NO
Anemia or Blood disorders	YES	NO
Abnormal Bleeding after extractions, surgery, or trauma	YES	NO
Emotional condition	YES	NO
Herpes or cold sores, fever blisters	YES	NO
AIDS or HIV positive	YES	NO
Migraine Headaches or frequent Headaches	YES	NO
Neurologic Disorders	YES	NO
Epilepsy, Seizures, or Fainting spells	YES	NO
Nervous/Anxious	YES	NO
Psychiatric/Psychological Care	YES	NO

ANY SPECIAL HEALTH CONCERNS NOT LISTED ABOVE:

_____

_____

Are you taking any of the following?

Aspirin	YES	NO
Anticoagulants (blood thinners)	YES	NO
Antibiotics or sulfa drugs	YES	NO
Blood pressure medication	YES	NO
Antidepressants or tranquilizers	YES	NO
Insulin, Orinase, or other diabetes drug	YES	NO
Thyroid medication	YES	NO
Nitroglycerin	YES	NO
Cortisone or other steroids	YES	NO
Osteoporosis (bone density) medicine	YES	NO
Recreational drugs	YES	NO
Heart medications	YES	NO
Other: _____	YES	NO

_____

If "YES" to any of the above, please list the name of the medication and dosage below

1. _____
2. _____
3. _____
4. _____

Are you ALLERGIC to, or have you reacted adversely to any of the following?

Latex materials	YES	NO
Penicillin or other antibiotics	YES	NO
Local anesthetics (ex: "Lidocaine")	YES	NO
Codeine or other narcotics	YES	NO
Sulfa drugs	YES	NO
Barbiturates, sedatives, or sleeping pills	YES	NO
Aspirin	YES	NO
Other:_____	YES	NO

List any other important medical information OR medication allergies here:

_____
_____
_____

Do you have any disease, condition, or problem not listed above? _____
_____ _____
Please add anything else you would like us to know about: _____
_____

Patient Name: _____
Date: _____

Medical Alert: (Allergy, Premed) _____

DENTAL HISTORY

Welcome to the office of Dr. Brooks Haney. In order to provide you with the best possible dental care please carefully complete the following Dental History Form to best of your ability. Thank you.

What is the main reason you are seeking dental treatment now? _____
_____
What was done at your last dental visit? _____
_____
Date of Last Dental Visit _____Last X-rays _____ Last Dental Cleaning _____
Name of Previous Dentist _____
Address (include state/zip) _____
Telephone of previous dentist _____

Have you ever had any serious trouble associated with previous dental treatment? YES NO
If so, explain _____
Are you nervous about having dental treatment? YES NO

If "YES", what is your biggest concern? _____

_____

How often do you have dental examinations? _____

How often do you brush? _____ How often do you floss? _____
Do you use any special dental aids? (Sonic brush, Water Pik, etc.) YES NO list: _____
Have you ever used or are you currently using Topical Fluoride? YES NO

Do you have any dental problems at this time? YES NO
If "Yes", please describe: _____

Questions about your TEETH:			DESCRIBE
Hot or cold sensitivity?	Yes	No	_____
Sensitivity to sweets?	Yes	No	
Biting or Chewing sensitivity?	Yes	No	_____
Loose teeth?	Yes	No	
Food impaction between teeth?	Yes	No	_____
Clenching and/or grinding?	Yes	No	
Change in your bite?	Yes	No	_____

Questions about your HABITS:			
Clench or grind while awake or asleep?	Yes	No	_____
Have tired jaws, especially in the morning?	Yes	No	
Snore or have OSA – Sleep Apnea?	Yes	No	_____
Do you have or use a CPAP machine?	Yes	No	
Do you wear a Dental Sleep Appliance	Yes	No	_____
Hold foreign objects between teeth?	Yes	No	
Smoke/chew – use tobacco products?	Yes	No	_____
Mouth breather – awake or asleep?	Yes	No	

CONTINUATION OF DENTAL HISTORY

Questions about ORAL HYGIENE:

Do you brush regularly? Yes No
How often do you brush? _____
Do you floss regularly? Yes No
Do you rinse with Fluoride? Yes No
Any other oral rinses? Yes No Other _____

Questions about your DENTAL HISTORY:

Have you had orthodontics (braces)? Yes No
Do you wear retainers? Yes No
Oral Surgery? Yes No
History of Periodontal Treatment (Gum)? Yes No
Has your bite been ground or adjusted? Yes No
Any serious injury to head or mouth? Yes No If so, describe _____
_____

Questions about your MOUTH & JAW:

Bleeding or sore gums? Yes No
Bad breath, odors, or unpleasant taste? Yes No
Parents or siblings had gum disease? Yes No
Frequent cold sores, blisters, lesions? Yes No
Swelling or lumps in the mouth? Yes No
Clicking or popping of the jaw? Yes No
Pain in joint, ear, or side of face? Yes No
Difficulty opening or closing? Yes No
Difficulty chewing on either side? Yes No
Headaches, neck or shoulder aches? Yes No
Sore muscles in neck, jaw, shoulders? Yes No

Questions about COSMETIC CONCERNS:

Satisfied with Appearance of your teeth? Yes No

If "NO", what would you like to change?
_____

Is there anything else you would like us to know?
_____

_____

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 medication to help keep my records updated.

Patient/Guardian Signature_____ Date_____

HISTORY REVIEW:

Dentist Signature: _____Date _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper dental care.

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent for the doctor's staff or designees to use and disclose any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, or operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is readily available.

5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____

Patient Date

_____

Parent or Guardian Relationship

Smiles of North Dallas

Everyone Deserves to Smile with Confidence

Smile Survey

In order to serve you better and to better understand your concerns, kindly answer the following few questions regarding your smile. Thank you.

How do you feel about your smile?

_____
_____
_____
_____
_____

Is there anything you might like to consider changing about your smile? In your words, with a magic wand, what would you change?

_____
_____
_____
_____
_____

Would you like to have whiter teeth? Would you like to have longer or shorter teeth? Would you like to have teeth that are not crowded or rotated?

_____
_____
_____
_____
_____

Do you have old crowns or filling that you think are unsightly? Do you have dark edges around a crown or filling?

_____
_____
_____
_____
_____

Would you like to learn more about how you can change your smile esthetics? YES NO

Are you familiar with 6 Month Smiles, Deep Bleaching, Porcelain Veneers and many of the more recent technological advances to help you achieve the smile you have always wanted? YES NO

Your Name: _____

Thank you for your Responses! Brooks Haney DDS

Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	**Date of Birth:**

This consent form allows Haney Dental PLLC to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Haney Dental PLLC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Haney Dental PLLC.

____ Initial I hereby authorize Haney Dental PLLC to use unsecured email and mobile phone test messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

____ Initial I hereby authorize that Haney Dental PLLC may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ Email __ Home Phone __ Office Phone __ Cell Phone

____ Initial I hereby authorize that Haney Dental PLLC may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

____ Initial I hereby authorize that Haney Dental PLLC may disclose my personal health information to the person who I have listed as my emergency contact.

____ Initial I hereby authorize that Haney Dental PLLC may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Haney Dental PLLC services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Haney Dental PLLC may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Haney Dental PLLC is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ 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** ◯

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

Height	Feet	Inches	**Neck Size**

Inches:

Date of Birth	Month	Day	Year

Optional: **ID Number**

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 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)	☐