Aspire® Family Dental

"HELPING BRING BUFFALO INTO THE FUTURE"

484 Ontario Street
Buffalo, NY 14207
(716) 873-0681

Please fill out all of the sections in **GREEN**. Sections in BLUE should be filled out only if it applies to you. You can use the 'arrow' or the 'tab' key to move to the next question or section. If you are online and do not see red outlined boxes below click **HERE** to download free ADOBE READER.

Today's Visit

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

What dental (mouth) related problem (if any) is responsible for your visit today?

_____

Patient Information

Name: _____

Address (no PO BOX):_____

City, State, Zip: _____

Home Phone: _____ _____Work Phone: _____ ext. _____

Cellular Phone: _____ Sex: M F

Marital Status: Married Single Divorced Separated Widowed

Birth Date (mm/dd/yyyy): _____ Age: _____ Soc. Sec. #: _____

Driver's License #: _____E-mail: _____

Would you like to receive information via e-mail: Y N Student Status: Full Time Part Time NA

Employment status: Full Time Part Time Retired NA Other _____

Employer Name: _____ Employer Phone #: _____

Address: _____

_____

_____

Responsible Party (If Other Than Above Patient)

Name. _____

Address (no PO BOX):_____

City, State, Zip: _____

Home Phone: _____ _____Work Phone: _____ ext. _____

Cellular Phone: _____ Sex: M F

Marital Status: Married Single Divorced Separated Widowed Driver's License #: _____

Birth Date (mm/dd/yyyy): _____Age: _____ Soc. Sec. #: _____ E-mail: _____

Employment status: Full Time Part Time Retired NA Other _____

Employer Name: _____

Address: _____

_____

_____

I am: Policy Holder for the Patient Y N

Primary Policy Holder Y N

Secondary Policy Holder Y N

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other _____

Insured Soc. Sec. #: _____ Insured Birth Date (mm/dd/yyyy): _____

Employer Name: _____ Insurance Company Name: _____

Address: _____ Address: _____

_____ _____

_____ _____

Employer ID: _____ Carrier ID: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other _____

Insured Soc. Sec. #: _____ Insured Birth Date (mm/dd/yyyy): _____

Employer Name: _____ Insurance Company Name: _____

Address: _____ Address: _____

_____ _____

_____ _____

Employer ID: _____ Carrier ID: _____

Aspire® Family Dental

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____ Today's Date (mm/dd/yyyy)_____

Although our dental team primarily treats the area in and around your mouth, it is IMPORTANT to remember that it is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all of the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	Please explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	Please explain: _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	Please explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	Please List: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	***
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	Please explain: _____
Are you on a special diet?	◯ Yes ◯ No	***
Do you use tobacco?	◯ Yes ◯ No	***
Do you use controlled substances?	◯ Yes ◯ No	***

Woman are you:

Pregnant/Trying to get pregnant? Yes ◯ No ◯ Using contraceptives? Yes ◯ No ◯ Nursing? Yes ◯ No ◯

Are you allergic to any of the following? ☐ No Allergies

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

☐ Other Please explain: _____

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

HIV Positive	Yes ◯ No ◯	Cortisone Medicine	Yes ◯ No ◯	Hemophilia	Yes ◯ No ◯	Radiation Treatments	Yes ◯ No ◯
Alzheimer's Disease	Yes ◯ No ◯	Diabetes	Yes ◯ No ◯	Hepatitis A	Yes ◯ No ◯	Recent Weight Loss	Yes ◯ No ◯
Anaphylaxis	Yes ◯ No ◯	Drug Addiction	Yes ◯ No ◯	Hepatitis B or C	Yes ◯ No ◯	Renal Dialysis	Yes ◯ No ◯
Anemia	Yes ◯ No ◯	Easily Winded	Yes ◯ No ◯	Herpes	Yes ◯ No ◯	Rheumatic Fever	Yes ◯ No ◯
Angina	Yes ◯ No ◯	Emphysema	Yes ◯ No ◯	High Blood Pressure	Yes ◯ No ◯	Rheumatism	Yes ◯ No ◯
Arthritis/Gout	Yes ◯ No ◯	Epilepsy or Seizures	Yes ◯ No ◯	High Cholesterol	Yes ◯ No ◯	Scarlet Fever	Yes ◯ No ◯
Artificial Heart Valve	Yes ◯ No ◯	Excessive Bleeding	Yes ◯ No ◯	Hives or Rash	Yes ◯ No ◯	Shingles	Yes ◯ No ◯
Artificial Joint	Yes ◯ No ◯	Excessive Thirst	Yes ◯ No ◯	Hypoglycemia	Yes ◯ No ◯	Sickle Cell Disease	Yes ◯ No ◯
Asthma	Yes ◯ No ◯	Fainting Spells/Dizziness	Yes ◯ No ◯	Irregular Heartbeat	Yes ◯ No ◯	Sinus Trouble	Yes ◯ No ◯
Blood Disease	Yes ◯ No ◯	Frequent Cough	Yes ◯ No ◯	Kidney Problems	Yes ◯ No ◯	Spina Bifida	Yes ◯ No ◯
Blood Transfusion	Yes ◯ No ◯	Frequent Diarrhea	Yes ◯ No ◯	Leukemia	Yes ◯ No ◯	Stomach/Intestinal Disease	Yes ◯ No ◯
Breathing Problems	Yes ◯ No ◯	Frequent Headaches	Yes ◯ No ◯	Liver Disease	Yes ◯ No ◯	Stroke	Yes ◯ No ◯
Bruise Easily	Yes ◯ No ◯	Genital Herpes	Yes ◯ No ◯	Low Blood Pressure	Yes ◯ No ◯	Swelling of Limbs	Yes ◯ No ◯
Cancer	Yes ◯ No ◯	Glaucoma	Yes ◯ No ◯	Lung Disease	Yes ◯ No ◯	Thyroid Disease	Yes ◯ No ◯
Chemotherapy	Yes ◯ No ◯	Hay Fever	Yes ◯ No ◯	Mitral Valve Prolapse	Yes ◯ No ◯	Tonsillitis	Yes ◯ No ◯
Chest Pains	Yes ◯ No ◯	Heart Attack/Failure	Yes ◯ No ◯	Osteoporosis	Yes ◯ No ◯	Tuberculosis	Yes ◯ No ◯
Cold Sores/Fever Blisters	Yes ◯ No ◯	Heart Murmur	Yes ◯ No ◯	Pain in Jaw Joints	Yes ◯ No ◯	Tumors or Growths	Yes ◯ No ◯
Congenital Heart Disorder	Yes ◯ No ◯	Heart Pacemaker	Yes ◯ No ◯	Parathyroid Disease	Yes ◯ No ◯	Ulcers	Yes ◯ No ◯
Convulsions	Yes ◯ No ◯	Heart Trouble/Disease	Yes ◯ No ◯	Psychiatric Care	Yes ◯ No ◯	Venereal Disease	Yes ◯ No ◯
						Yellow Jaundice	Yes ◯ No ◯

Please list other comments about your health or if you had any other serious illness not listed above:

_____

_____

This next section deals with screening information. We have advanced screening and diagnostic equipment for both Obstructive Sleep Apnea (OSA) and Temporomandibular Disorder (TMD). As usual, I am making sure our patients have access to what most other dental patients in WNY do not have! Conditions such as OSA can be life threatening. We have letters of recommendation from this area's top Sleep Specialists and the associated Sleep Labs because of our dedication and knowledge in this area. OSA affects about 25% of the population. Therefore everyone does not need to be treated. Since this is a medical condition, we can bill your Medical Insurance and NOT take away anything from your current dental benefits. We have already signed up with MANY Medical Insurance companies, including Medicare! Below are basic screening questions that can guide us more to the people who are at risk. Screening forms are NOT perfect! If you think there may be a problem then it is VERY important to mention this to your MD and us!! TMD related issues affect many patients by way of jaw pain and discomfort, headaches, premature breaking and wearing of teeth, restorations breaking down much earlier than normal, etc. As you can see, we are taking a whole body approach to your treatment. Please follow the directions on the following page. You are almost done!!!

PATIENT NAME _____ Birth Date _____Today's Date (mm/dd/yyyy)_____

Obstructive Sleep Apnea (OSA)

Epworth Sleepiness Scale

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

	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
Driving a car stopped for a few minutes in traffic	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Please add all checked numbers and write total (if not automatically added): 0_____

Subjective Sleep Evaluation

Please highlight either 'Yes' or 'No' from each question

	No (0)	Yes (1)
Do you snore?	0	1
You or your spouse would consider your snoring louder than a person talking	0	1
Your snoring occurs almost every night	0	1
Your snoring is bothersome to your bed partner	0	1
Do you feel that in some way your sleep is not refreshing or restful?	0	1
Do you wake up in the morning or at night with headaches?	0	1
Do you experience fatigue during the day and have difficulty staying awake?	0	1
Do you have trouble remembering things or paying attention during the day?	0	1
Do you have high blood pressure?	0	1

Please add all checked numbers and write total (if not automatically added): 0_____

Prior Diagnosis

Prior Diagnosis

	No (0)	Yes (1)
Have you previously been diagnosed with OSA?	0	1

If Yes:
When were you diagnosed? (Appox. Month/year) _____
Were you put on CPAP Therapy for treatment? _____
Are you still using your CPAP every night? _____

Please add all checked numbers and write total (if not automatically added): 0_____

OFFICE USE ONLY
Advanced screening criteria: If 'yes' to any below, Pt. should be scheduled for advanced OSA screening.
0___ ESS ≥ 8 0___ SSE ≥ 3 0___PD ≥ 1

Temporomandibular Disorder (TMD or TMJ

Left (L), Right (R), Both (B), None (N)

Head Pain	L	R	B	N
Front of your head				
Top of your head				
Back of your head				
Temple area				

Jaw Pain	L	R	B	N
Opening your mouth				
While chewing				
During the day				
At night time				

Jaw Symptoms	L	R	B	N
Jaw popping				
Jaw clicking				
Jaw locks open				
Jaw locks closed				

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Please fill out all of the below information. In order to save you time, we have already placed common responses in many of the spaces below. You do not have to keep these answers. You can freely cross them off and change them! IF YOU ARE ELECTRONICALLY SUBMITTING THIS FORM YOU CAN SIGN THIS ON THE DAY OF YOUR APPOINTMENT.

Patient Information:

Name: _____
Address: _____
_____
Phone #: _____

I authorize the office of Aspire® Family Dental, PLLC dba Aspire® Family Dental to release health information identifying me (including if applicable, information about HIV infection, substance abuse treatment and mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

ALL

2. To whom may the information be released name(s) of recipient(s)?

NAME & RELATIONSHIP TO YOU:

3. The Purpose(s) for the release (if appropriate, it is acceptable to state "at the request of the individual")?

TO OBTAIN REQUIRED INFORMATION

4. Expiration date or event relating to the individual or purpose for the release:

NONE

It is completely your decision whether or not you sign this form. We can't refuse to treat you if you choose not to sign this form.

If you sign this authorization, you can revoke it at a later date. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written statement to the below address telling us your authorization is revoked: Aspire® Family Dental, PLLC dba Aspire® Family Dental, 484 Ontario Street, Buffalo, NY 14207

When your authorization is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, State or Federal Law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

The next page is the last one!!!!!!!!!!

COMBINED SIGNATURE SECTION – YOU MUST READ, AND SIGN BELOW PRIOR TO TREATMENT

By signing below you are stating that you understand, acknowledge, agree and will abide by all the parts listed below (PARTS 1-4):

PART 1

You have read, understand, and agree to abide by all of the terms, and conditions described in the above mentioned OFFICE POLICIES/CONTRACT (pgs. 3-5). Also, you state the PATIENT REGISTRATION on pg. 8 and MEDICAL HISTORY form located above on pgs. 9-10 was filled out truthfully. I additionally acknowledge receipt of a copy of Aspire® Family Dental, PLLC dba Aspire® Family Dental NOTICE OF PRIVACY PRACTICES (pg. 6-8) & AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION (pg. 12).

PART 2

COLLECTION AGREEMENT: In case of default of payment of the required installments, the whole of the principal sum unpaid at that time shall become immediately due and payable at the option of the holder of this CONTRACT [Aspire® Family Dental, PLLC dba Aspire® Family Dental]. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts. These costs and/or fees will be added to the principal sum as stated above.

PART 3

ASSIGNMENT AND RELEASE: I have reviewed this statement of charges, and hereby authorize payment directly to Aspire® Family Dental, PLLC dba Aspire® Family Dental of insurance benefits otherwise payable to me. I authorize release of any information relating to this claim. I am responsible for ALL costs of dental related treatment(s) and fee(s).

PATIENT NAME (PRINT): _____DATE (mm/dd/yyyy): _____

GUARANTOR SIGNATURE: _____DATE (mm/dd/yyyy): _____

CONTRACT HOLDER: ASPIRE® FAMILY DENTAL, PLLC dba Aspire® Family Dental DATE: _____

If you are online ONLY!

Submit -OR- **SAVE**

If you use Microsoft Outlook or Outlook Express, Please click Submit

If you use yahoo, gmail, etc., please click and save this file to your desktop. Send an email to the below address and attach your saved file.
Address: aspireontario@aspirefamilydental.com

Any Questions? Please contact us at (716) 873-0681