EPWORTH SLEEPINESS SCALE

Name_____DOB_____

Date _____Gender_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

*****It is important that you answer each question as best as you can.*****

Situation	**Chance of dozing** (out of 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. a theatre 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	
Total out of 24	

Score Interpretation:

(1-10) Normal Range (10–16) Excessively sleepy (16-24) Abnormally sleepy

TIME 09:00 AM DATE 6/22/2022

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Pre-medication

Referred By

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Medical Background Information March 2023

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat 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, co
Thank you for answering the following questions.

Chief Complaint or Concern?	◯ Yes ◯ No	If yes
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had any surgery in your lifetime?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have your ever had your tonsils and/or adenoids surgically removed?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs, include any over-the-counter?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

Social History

Do you use tobacco? If yes, for how long, and how much a day?	◯ Yes ◯ No	If yes
Do you use recreational drugs (such as marijuana or cocaine)? If yes, which ones?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

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

AIDS/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/Hypertension ○ 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	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/ Nasal Allergies ○ 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
Loss of Appetite ○ Yes ○ No	Sweats ○ Yes ○ No	Fever ○ Yes ○ No	Fatigue ○ Yes ○ No
Weight Gain ○ Yes ○ No	Weight Loss ○ Yes ○ No	GERD ○ Yes ○ No	Black or Bloody Stools: Diarrhea ○ Yes ○ No
Nausea/Vomiting ○ Yes ○ No	Abdominal Pain ○ Yes ○ No	Wheezing ○ Yes ○ No	Poor Exercise Tolerance ○ Yes ○ No
Bed Wetting ○ Yes ○ No	Frequent Urination ○ Yes ○ No	Blood in Urine ○ Yes ○ No	Erectile Dysfunction ○ Yes ○ No
Sneezing ○ Yes ○ No	Runny Nose ○ Yes ○ No	Itchy Eyes or Nose ○ Yes ○ No	Nasal Congestion ○ Yes ○ No
Blurry Vision ○ Yes ○ No	Double Vision ○ Yes ○ No	Vision Loss ○ Yes ○ No	Daytime Shortness of Breath ○ Yes ○ No
Nighttime Shortness of Breath ○ Yes ○ No	Unusual Moles ○ Yes ○ No	Dryness ○ Yes ○ No	Heat Intolerance ○ Yes ○ No
Temporomandibular Joint (TMJ) Pain/Jaw D ○ Yes ○ No			

Continued....

Indigestion/Heartburn ○ Yes ○ No	Vertigo ○ Yes ○ No	Tubes in Ears ○ Yes ○ No	Depressed Mood ○ Yes ○ No
Nervousness or Anxiety ○ Yes ○ No	Hallucinations ○ Yes ○ No	Memory Loss ○ Yes ○ No	Trouble Concentrating ○ Yes ○ No
Dizziness ○ Yes ○ No	Headaches ○ Yes ○ No	Numbness ○ Yes ○ No	Restless Leg Syndrome ○ Yes ○ No
Excessive Stress ○ Yes ○ No	Difficulty with Focus ○ Yes ○ No	Passing Out ○ Yes ○ No	Involuntary Tongue Biting ○ Yes ○ No
Weakness ○ Yes ○ No	Hoarseness ○ Yes ○ No	Sinus Congestion ○ Yes ○ No	Sore Throat ○ Yes ○ No
Hearing Loss ○ Yes ○ No	Cold Intolerance ○ Yes ○ No	Cold Hands/Feet ○ Yes ○ No	Decreased Libido ○ Yes ○ No
Stiff/Sore Joints ○ Yes ○ No	Muscle Pain ○ Yes ○ No	Red or Swollen Joints ○ Yes ○ No	Rash ○ Yes ○ No
Ankle Swelling ○ Yes ○ No	Difficulty Urinating ○ Yes ○ No	Hives ○ Yes ○ No	Cough ○ Yes ○ No
Excessive Thirst ○ Yes ○ No	Constipation ○ Yes ○ No	Palpitations ○ Yes ○ No	

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Family History

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

High blood Pressure/Hypertension ○ Yes ○ No	Diabetes ○ Yes ○ No	Chronic Insomnia ○ Yes ○ No	Heart Disease ○ Yes ○ No
Overweight/Obesity ○ Yes ○ No	Restless Legs Syndrome ○ Yes ○ No	Stroke ○ Yes ○ No	Snoring ○ Yes ○ No
Multiple Sclerosis ○ Yes ○ No	Congestive Heart Failure ○ Yes ○ No	Sleep Apnea ○ Yes ○ No	Sleep Walking ○ Yes ○ No
Depression ○ Yes ○ No	Anxiety ○ Yes ○ No		

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:

X_____ Date:_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION.

Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1 Do you like the appearance of your teeth and your smile? □**Yes** □**No**
If not, explain _____
_____

2 Are your teeth all in alignment (straight)? □**Yes** □**No**
If not, explain _____
_____

3 Do you have spaces that you don't like? □**Yes** □**No**
If yes, explain _____
_____

4 Do you like the color of your teeth? □**Yes** □**No**
If not, explain _____
_____

5 Do you like the shape of your teeth? □**Yes** □**No**
If not, explain _____
_____

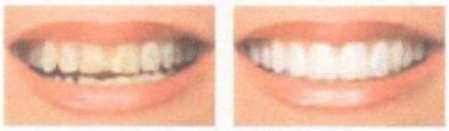
6 Are your teeth...
Chipped □**Yes** □**No** Protruding □**Yes** □**No** Hidden □**Yes** □**No**
If yes, explain _____
_____

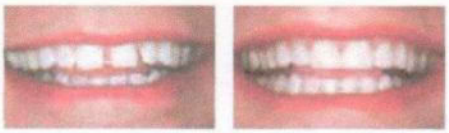
7 Are your teeth wearing on the biting surfaces? □**Yes** □**No**
If yes, explain _____
_____

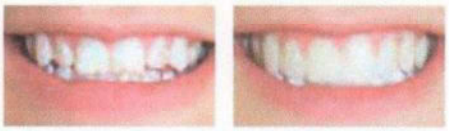
8 Are there old fillings or dental work you don't like looking at? □**Yes** □**No**
If yes, explain _____
_____

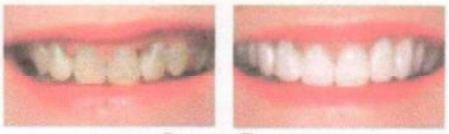
9 What would you like to change the most in the appearance of your teeth?
_____
_____

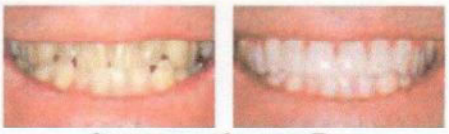
10 How would you like your teeth to look
_____
_____

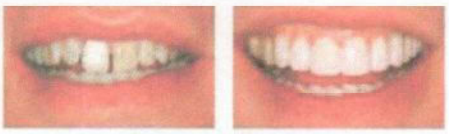

Stained and Chipped


Spaces


Calcification Stains


Fanged Teeth

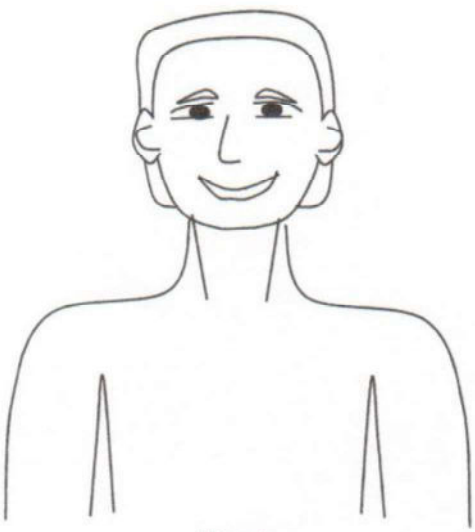

Stained and Crooked Teeth


Porcelain Crowns

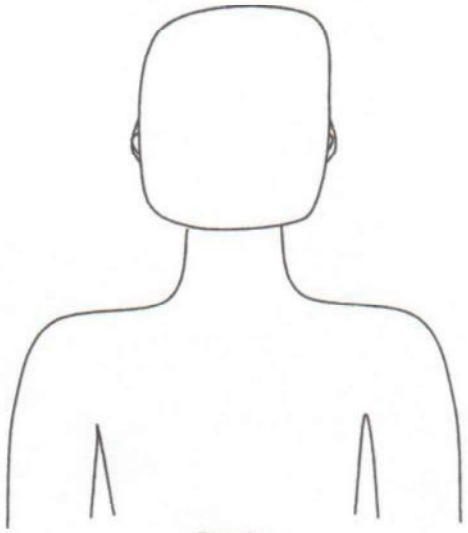

Beautiful Smile

MIYASAKI DENTAL

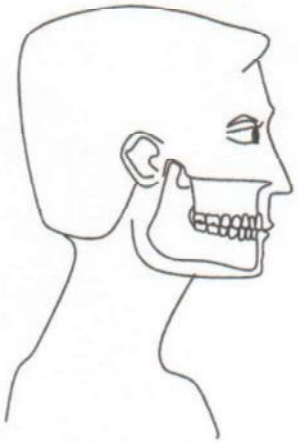
Mark areas where you are experiencing any discomfort



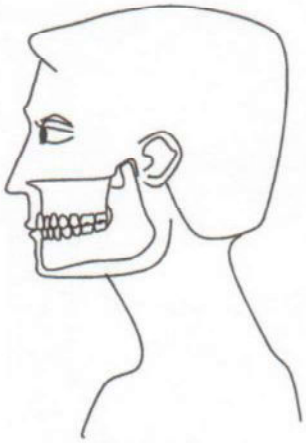
Front



Back



Right side



Left side

Do you experience any of the following (check all that apply)?

- ☐ Clicking/popping jaw joints
- ☐ Head pain
- ☐ "Migraine" type headaches
- ☐ Ringing in your ears
- ☐ Vertigo or dizziness
- ☐ Neck pain
- ☐ Arm and/or finger numbness and/or pain
- ☐ Difficulty swallowing
- ☐ Clenching and/or grinding of your teeth
- ☐ Can't find your comfortable bite
- ☐ Limited opening of your mouth
- ☐ Pain behind your eyes

MIYASAKI
DENTAL

Financial Policy

As a result of the amount of time that we invest in your treatment, along with material and overhead costs, payment is expected in full at the time of service. For your convenience, ask our team about our **Plan for Health** or **Care Credit** financing options.
If you have dental insurance, we will contact your insurance company and determine as close as is possible what your portion is to pay on the date of service. This information is an estimate only and we cannot guarantee its accuracy. After your insurance company pays their portion, we will inform you of what balance, if any, is outstanding for you to pay. This amount will be due upon notification. Please note that your insurance policy is a contract between you and your insurance carrier. It is your responsibility to understand your plan benefits. Any past due balance is subject to a monthly finance charge. **In the unfortunate circumstance that your account becomes more than 90 days overdue, our practice has the right to send the account to our collection services.**

_____
Initial Here

Appointment Policy

The complex nature of your dental treatment requires a series of appointments with explicit amounts of time periods between them to allow us to complete your treatment to the high standards that we constantly strive to achieve. It is imperative that your appointments be maintained in order, otherwise your treatment may be delayed by several months. **Should you need to change a scheduled appointment, we would appreciate the courtesy of being informed at least 2 working days in advance. If your appointment is for 2 hours or more, we require at least 4 working days notice.** Due to the large amount of time involved in prosthetic treatment, other patients who may wish to take your appointment time require several days' notice in order to accommodate their schedules. **We reserve the right to charge your account a $50 missed appointment fee if appointments are cancelled without sufficient notice.**

If you are seen for any reason **after our business hours, please be advised there is a separate after-hours visit fee that will apply of $411.00,** in addition to your treatment cost.

_____
Print Name

_____
Signature