PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ M: _____

Preferred Name (What would you like us to call you?): _____

Address: _____ Apt #: _____

City: _____State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

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

Birth Date: _____ Social Security #: _____ Drivers Lic. # & State: _____

Primary Language Spoken: _____ Is Translator needed for appointments?: YES NO

Email: _____ (Parent Email if minor)

(Email is used for reminders, appointment confirmations and newsletters/promotions)

How did you hear about our office? _____

PRIMARY DENTAL INSURANCE INFORMATION:

Subscriber's First Name: _____ Last Name: _____ M: _____

Subscriber's Birth Date: _____ Subscriber's Social Security #: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Employer (if group policy): _____ Group #_____ Patient ID: _____

Insurance Co. Name: _____ Phone # _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

*** Please advise us if you have secondary dental insurance****

PARENT INFORMATION (COMPLETE ONLY IF PATIENT IS A MINOR):

Mother's Name: First Name: _____ Last Name: _____ M: _____

Birth Date: _____ Social Security #: _____ Drivers Lic # & State: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Father's Name: First Name: _____ Last Name: _____ M: _____

Birth Date: _____ Social Security #: _____ Drivers Lic # & State: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Child Lives With: □ Both Parents □ Mother □ Father □ Other _____

Responsible Party: □ Mother □ Father □ Other _____

NEW ORLEANS DENTAL CENTER
Medical History

Patient Name_____ Birth Date_____ Date Created_____

Please be aware that a patient's health problems, or medication that is taken, could have an important interrelationship with the dental care received.

Are you under a physician's care now? □Yes □No If yes _____

Have you been hospitalized or had a major operation, other than childbirth? □Yes □No If yes _____

Have you ever had a serious head or neck injury? □Yes □No If yes _____

Are you taking any medications—either prescriptions or over-the-counter, including herbals? □Yes □No If yes _____

Have you ever taken Fosamax, Boniva, or any other medications containing bisphosphonates? □Yes □No If yes _____

Have you ever been told to take antibiotics prior to dental treatment regarding heart or joint protection? □Yes □No If yes _____

Have you had eye surgery in the past 8 weeks? □Yes □No If yes _____

Do you use tobacco or controlled substances? □Yes □No If yes _____

Are you nervous about dental treatment? □Yes □No If yes _____

Women: Are you…

□ Pregnant/Trying to become pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic or sensitive to any of the following?

□ Acrylic □ Codeine □ Latex □ Local Anesthetics

□ Metal (nickel, stainless steel) □ Penicillin □Sulfa Drugs □ NO KNOWN ALLERGIES

Any other allergies or sensitivities? □Yes □No If yes _____

Emergency Contact Person(s)/Comments:

Please check "yes" if you currently have, or you've previously had, any of the following:

AIDS/HIV Positive	□Yes □No	Cortisone/Steroid Medicine	□Yes □No	Herpes	□Yes □No	Psychiatric Care	□Yes □No
Alzheimer's Disease	□Yes □No	Diabetes	□Yes □No	High Blood Pressure	□Yes □No	Radiation Treatment	□Yes □No
Anaphylaxis	□Yes □No	Drug Addiction	□Yes □No	High Cholesterol	□Yes □No	Renal Dialysis	□Yes □No
Anemia	□Yes □No	Emphysema/COPD	□Yes □No	Hives/Rashes	□Yes □No	Restless Leg Syndrone	□Yes □No
Angina	□Yes □No	Environmental Allergies	□Yes □No	Hypoglycemia	□Yes □No	Rheumatic Fever	□Yes □No
Arthritis	□Yes □No	Epilepsy	□Yes □No	Irregular Heartbeat	□Yes □No	Scarlet Fever	□Yes □No
Artificial Heart Valve	□Yes □No	Excessive Bleeding	□Yes □No	Jaundice	□Yes □No	Shingles	□Yes □No
Artificial Joint	□Yes □No	Excessive Thirst	□Yes □No	Kidney Problems/Disease.	□Yes □No	Sickle Cell Disease	□Yes □No
Asthma	□Yes □No	Fainting/Dizziness	□Yes □No	Leukemia	□Yes □No	Sinus Problems	□Yes □No
Blood Disease	□Yes □No	Frequent Cough	□Yes □No	Lichen Planus	□Yes □No	Sleep Apnea	□Yes □No
Blood Transfusion	□Yes □No	Frequent Diarrhea	□Yes □No	Liver Disease	□Yes □No	Stomach/Intestinal Disease	□Yes □No
Breathing Problems	□Yes □No	Frequent Headaches	□Yes □No	Low Blood Pressure	□Yes □No	Stroke/TIAs	□Yes □No
Bruise Easily	□Yes □No	Glaucoma	□Yes □No	Lung Disease	□Yes □No	Swelling of Limbs/Face	□Yes □No
Cancer	□Yes □No	Heart Attack/Failure	□Yes □No	Lupus Erythematosus	□Yes □No	Thyroid Disease	□Yes □No
Chemotherapy	□Yes □No	Heart Murmur	□Yes □No	Mitral Valve Prolapse	□Yes □No	Tonsillitis	□Yes □No
Chest Pains	□Yes □No	Heart Pacemaker	□Yes □No	Osteoporosis/Osteopenia	□Yes □No	Tuberculosis	□Yes □No
Cold Sores/Fever Blisters	□Yes □No	Heart Trouble/Disease	□Yes □No	Pain in Jaws/TMJ Problems	□Yes □No	Tumor ors or Growths	□Yes □No
Congenital Heart Disorder	□Yes □No	Hemophilia	□Yes □No	Parathyroid Disease	□Yes □No	Ulcers (gastrointestinal)	□Yes □No
Convulsions or Seizures	□Yes □No	Hepatitis	□Yes □No				

Have you had any condition not listed above? □Yes □No If yes _____

To the best of my knowledge, the questions on this form have been accurately and completely answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. I agree that it is my responsibility to inform New Orleans Dental Center of any changes in my/the patient's medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date_____

NEW ORLEANS DENTAL CENTER
CONSENT FOR TREATMENT AND PATIENT RESPONSIBILITY

The doctors and staff feel confident in the thorough explanations we give regarding the treatment that we recommend. We are always happy to explain anything, as many times as needed. Because every body is different, with different immune system health and unique reactions, there are risks associated with any dental treatment. These include the administration of any local or general anesthetic agent, medications to produce conscious sedation, and/or pre-medication prior to dental treatment. Some of the risks/complications are, but are not limited to, the following:

- Infection and/or swelling
- Allergic or other reactions to drugs or medicaments (such as nausea, vomiting)
- Bleeding
- Bacterial endocarditis
- Dry socket
- Trismus (jaw pain or difficulty opening mouth)
- Paresthesia (numbness of face and/or mouth and/or tongue)—usually transient but could be permanent
- Loss of teeth and/or bone
- Opening between mouth and sinus or mouth and nose
- Failure of treatment to accomplish main purpose
- Loosening or additional spacing of teeth
- Changes in occlusion (biting/chewing)
- Delay or failure of healing of the surgery site
- Injuries to adjacent teeth, restorations and/or hard/soft tissue
- Incomplete removal of tooth/root
- Swallowing or aspiration of objects
- Tooth or fragment(s) in maxillary sinus
- Breakage of root(s) and/or retained root fragment(s)
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Jaw muscle cramps or spasms
- Instrument breakage
- Increase in existing TMJ (jaw joint) dysfunction, known or unknown
- Sloughing (unanticipated loss of soft tissue and/or bone)
- Pain referred to ear/neck/head
- Death (extremely rare)

Additional oral surgery, hospitalization, and/or further treatment may be required in the event of any complication(s). Be assured that we are careful to minimize the potential for any risks associated with dental treatment.

I understand that, if the patient is under 18 yrs old, a parent or legal guardian must bring the patient to his/her first visit. For all subsequent dental visits, any adult authorized by the parent may bring the patient to his/her appointment. For orthodontic adjustment visits, parents are not required to be in the office during the appointment.

I understand that it is my responsibility for payment of dental services provided for my dependents or me, due and payable at the time of services rendered, unless prior financial arrangements have been made, and regardless of any presumed insurance benefit. Any fees quoted are valid for six (6) months from the date of the treatment plan. **No refunds for professional services rendered will be given.**

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this form. I was given adequate opportunity to ask any questions and all questions were answered to my satisfaction. I hereby authorize the dentist and/or associates, hygienists, assistants of their choice to perform for (patient's name:)
_____the diagnostic, surgical, orthodontic and/or dental treatment agreed upon between the doctor and the patient or parent/guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. This consent form will remain valid unless revoked by me in writing.

_____ _____
Patient's or Parent/Guardian's Signature Date

_____
Witness

CONSENT FOR PHOTOGRAPHY

I, _____ (Patient), hereby consent for New Orleans Dental Center professionals to take photographs, and/or videos of my face, smile, jaws and/or teeth, before, during and after treatment.

I understand that the photographs may be used for any of the following:

- *Dental Records*
- *Dental Research*
- *Dental Education including lectures, seminars, demonstrations, professional publications, such as journals or books*
- *Marketing material, including websites and printed materials, patient education*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face photo used for any of the above purposes.

_____ _____

Patient's or Guardian's Signature Witness

_____

Date

Patient's Name: _____

Smile Assessment

Please check all that apply:

Would you like your teeth to be:

More white? ❑

Straighter in appearance? ❑

Is anything holding you back from a better smile:

Fear? ❑

Lack of time? ❑

Cost? ❑

Any other issues about your smile you'd like to discuss?

PLEASE FILL OUT IF YOU ARE AGE 18 OR OLDER.

Patient's Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:

Chance of dozing: 0=never, 1=slight, 2=moderate, 3=high

PLEASE CIRCLE ONE RESPONSE FOR EACH QUESTION

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

Total Score: _____

Section 2: Patient Evaluation

Fill in the blanks, and circle one yes or no response for each question:		No(0)	Yes(1)
BMI (See Attached Chart):	_____ Is it greater than or equal to 30?	0	1
Neck Circumference:	_____ Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15lbs in the past 6 months?.....		0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response to each question:	No(0)	Yes(1)
Have you been told that you snore?.....	0	1
You, or your spouse, would consider your snoring louder than a person talking….	0	1
Does your snoring occur almost every night?……..	0	1
Is 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 often wake up in the middle of the night in order to urinate?.....	0	1
Do you tend to take a long time to fall asleep at night?.....	0	1
Do you often wake up and have a difficult time falling asleep again?.....	0	1
Do you wake up at night or in the mornings 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

Total Score: _____

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you ever had a sleep study?.....	0	1
Have you previously been diagnosed with sleep apnea?.....	0	1

If Yes:

When were you diagnosed? (Approx. mo/yr) _____/_____

Were you put on CPAP Therapy for treatment? _____

Are you still wearing your CPAP every night? _____

Patient's Signature:_____ **Date:** ____/____/_____

OFFICE USE ONLY: STAFF INITIALS _____ DOCTOR INITIALS _____

New Orleans DENTAL CENTER

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity														
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	5 ft – 60inches, 6ft – 72inches											Body Weight (pounds)																								
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	165	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.*