HEALTH HISTORY

Former Dentist				Last Visit				**FOR OFFICE USE ONLY**	
Physicians Name				Phone #				U.D.	COMMENTS
Are you now being treated by a physician?				Yes		No			
HAVE YOU HAD ANY ILL EFFECTS FROM ANY OF THE FOLLOWING?									
Local Anesthetic	Yes	No		Codeine	Yes	No			
Penicillin.	Yes	No		Erythromycin	Yes	No			
Amoxicillin	Yes	No		Aspirin	Yes	No			
Sulfa	Yes	No		Any other drug	Yes	No			
Latex	Yes	No		Please list					
Are you taking any medication to thin your blood?				Yes		No			
Have you had any problem with abnormal bleeding?				Yes		No			
Are you having any form of treatment for cancer?				Yes		No			
Have you been tested for HIV?				Yes		No			
If so the results were				Positive		Negative			
Are you required to take Pre-Med prior to any dental visits?				Yes		No			
HAVE YOU EVER HAD?									
Heart Trouble	Yes	No		Diabetes	Yes	No			
Heart Surgery	Yes	No		Epilepsy or Seizures	Yes	No			
History Valve Problems	Yes	No		Tumor	Yes	No			
Heart Valve Replacement	Yes	No		Kidney/Liver Disease	Yes	No			
Hepatitis	Yes	No		Tuberculosis	Yes	No			
Artificial Joint placements	Yes	No							
High/Low Blood Pressure	High	Low		Normal					
Have you had surgery in the past 2 years?				Yes		No			
If yes, please describe									
Have you had any pins placed in the past 2 years?				Yes		No			
Radiation Treatment to your Head or Neck?				Yes		No			
If you smoke, how many packs a day?									
Female:	Are you pregnant?			Delivery Date					
Do you take medicine to strengthen your bones?				Yes		No			
Do you take aspirin daily?				Yes		No			
PHARMACY									
PLEASE LIST PRESCRIPTION MEDICATIONS BELOW:									
1		6		11					
2		7		12					
3		8		13					
4		9		14					
5		10		15					
Patient/Parent signature									
Date									

CHILD REGISTRATION

Name _____ Date of Birth _____

Address _____ Home Phone _____

City, ST, Zip _____

Father's Name _____ Mother's Name _____

Father's Employer _____ Business Phone _____

Mother's Employer _____ Business Phone _____

Person Responsible for Account _____

Address IF DIFFERENT FROM ABOVE _____

City, ST, Zip _____

****DENTAL INSURANCE? YES NO If **YES, Please fill in "Insurance Information" below**

ADULT REGISTRATION Date _____

Name _____ Spouse _____

Address _____ Home Phone _____

City, ST, Zip _____

Social Security # _____ Date of Birth _____

Emergency Contact _____ Phone # _____

Employer - Self _____ Business Phone _____

Employer - Spouse _____ Business Phone _____

I give permission for my dentist and his clinical teams to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.

Signature _____

INSURANCE INFORMATION

Person who has the insurance contract: Self Spouse Other _____

Employee Subscriber Name _____

Employee Social Security # _____ Date of Birth _____

Employer's Name _____

Name of Insurance Co. _____

Complete Address _____

Group # _____ Subscriber # _____ Policy # _____

I authorize the release of any information relating to my dental claims. I assign benefit payments to be paid directly to Dr. James Albrecht from my insurance company.

Signature: _____

The Epworth Sleepiness Scale

Name: _____

Today's Date: _____

Your Age (years): _____

Your Sex: ___ Male ___ Female

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 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.

Situation: Chance of dozing

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (e.g. theater or 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 lunch without alcohol _____

In a car, while stopped for a few minutes in the traffic _____

Thank you for your cooperation!

Initial Evaluation Questionnaire

Date: _____/_____/_____ Code Number:_____
Mo. Day Year

Sex: □ 1 Male □ 2 Female

Date of Birth: _____/_____/_____ Age:_____
Mo. Day Year

Marital Status: □ 01 Single □ 05 Widowed
□ 02 Married □ 06 Divorced and remarried
□ 03 Divorced □ 07 Domestic partner
□ 04 Separated

Race: □ 1 Caucasian □ 3 Asian □ 5 Other (specifiy):_____
□ 2 African American □ 4 Hispanic

Is there usually a bed partner to observe your sleep? □ 1 Yes □ 2 No

During the last week:

	Never	Rarely	Some-times	Often
1. Have you snored or have you been told that you do?	□1	□2	□3	□4
2. Have you had choking or shortness of breath sensations at night?	□1	□2	□3	□4
3. Have you woken up during sleep?	□1	□2	□3	□4
4. Have you had morning fatigue or fogginess or woken up feeling unrefreshed?	□1	□2	□3	□4
5. Have you woken up with a headache?	□1	□2	□3	□4
6. Have you had chronic sleepiness, fatigue or weariness that you can't explain?	□1	□2	□3	□4
7. Have you fallen asleep during the day, particularly when not busy?	□1	□2	□3	□4
8. Have you fallen asleep reading or watching television?	□1	□2	□3	□4
9. Have you fallen asleep during the day against your will?	□1	□2	□3	□4
10. Have you had to pull off the road while driving due to sleepiness?	□1	□2	□3	□4
11. Have you been more irritable and short-tempered?	□1	□2	□3	□4

12. Have you felt your memory and/or intellect is impaired? □1 Yes □2 No

13. Have you been told that you stop breathing while asleep? □1 Yes □2 No