GRAND DENTAL STUDIO
GENERAL COSMETIC IMPLANT SEDATION

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Welcome to Grand Dental Studio.

We are so honored you have chosen our dental team to take care of you! Our mission at Grand Dental Studio is to provide general, sedation, implant, and cosmetic dental care in a way that we hope changes your perception of dentistry.

At Grand Dental Studio, we believe that it's our focus on the details that set us apart from other dental care providers. Every day we strive to put our patients first by starting and ending our appointments on time and treating everyone like family. We partner with you to provide superior general, cosmetic, implant, and sedation dentistry services for the entire family. We believe in **total wellness** so please talk to us about your health including but not limited to teeth and gum concerns, headaches, fatigue, snoring, and any dental hygiene questions you may have for you or your family.

We want to encourage more people to take care of their dental health. Recent statistics indicate that a little over half of the people in Oklahoma go to a dentist regularly. That is why we are offer a FREE First Visit™. This includes exam with the doctor and x-rays. Please tell your friends about this program.

We invite you to ask questions because we want to create a lifelong relationship with you. **We seek daily to be Oklahoma's Best Dental Experience™.**

Thank you for being here today!

Oklahoma's Best dental experience™

PATIENT REGISTRATION

Today's Date _____

Patient's Name | Sex: M F | Birthdate | Age

Home Address | City | State | Zip

Please Circle One: Single Married Separated Widow | Your Soc. Sec. #

Home Ph. # | Cell Ph. # | E-mail Address

Your Employer | Work Ph. # | How Long Employed

Are you a full time student? ☐ Yes ☐ No If so, where?

If patient is minor, we need: | Mother's DOB | Father's DOB

Person responsible for account | DOB | SSN # | Relationship

Name of spouse (parent if minor) | Spouse's (parent's) Soc. Sec. #

Address | City | State | Zip

Spouse's (parent's) Employer | Work Ph. # | Cell Ph. #

EMERGENCY INFORMATION
Name, address & telephone of a relative not living with you.

Dental concerns you wish to discuss today?

How did you hear about our office? ☐ Sign ☐ Facebook ☐ Website ☐ Mail ☐ Advertisement ☐ Referral

If referral, please let us know who we can thank. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name | Relationship to Patient

Insured's Employer

Insurance Co.

Insurance Co. Address

Phone # | DOB

SS#/Member ID # | Group #

MEDICAL HISTORY

Patient Name_____ Nickname_____ Age _____

Name of Physician / and their specialty_____

Most recent physical examination _____Purpose_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization of illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO)_____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints)		
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners)_____	☐	☐
11. anemia or other blood disorder_____	☐	☐
12. prolonged bleeding due to a slight cut (INR>3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep disorders (i.e. sleep apnea, snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs_____	☐	☐
23. diabetes (HbA1c=____) _____	☐	☐
24. stomach or duodenal cancer_____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐
27. arthritis, rheumatoid arthritis, lupus_____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions, (seizures) _____	☐	☐
32. neurologic disorders (ADD, ADHD, prion disease)_____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. STI/STD_____	☐	☐
37. hepatitis (type____) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy, immunosuppressive _____	☐	☐
42. emotional problems_____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)_____	☐	☐
48. taking medication for weight management (i.e. fen-phen)_____	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued_____	☐	☐
51. experiencing frequent headaches _____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
53. often unhappy or depressed _____	☐	☐
54. FEMALE - taking birth control pills_____	☐	☐
55. FEMALE - pregnant_____	☐	☐
56. MALE - prostate disorders_____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE

Ask for an additional sheet if you are taking more than 6 medications.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

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STOP-BANG Questionnaire for Obstructive Sleep Apnea (OSA)

1. Do you **Snore** loudly (louder than talking or loud enough to be heard through closed doors)?
   ☐ Yes ☐ No
2. Do you often feel **Tired**, fatigued, or sleepy during daytime?
   ☐ Yes ☐ No
3. Has anyone **Observed** you stop breathing during your sleep?
   ☐ Yes ☐ No
4. Do you have or are you being treated for high blood **Pressure**?
   ☐ Yes ☐ No
5. **Body** Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?
   ☐ Yes ☐ No

   BMI Formula: $$BMI = \frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches)}}$$
6. **Age** over 50 yr old?
   ☐ Yes ☐ No
7. **Neck** circumference greater than 40 cm?
   ☐ Yes ☐ No
8. **Gender** male?
   ☐ Yes ☐ No

Scoring:
Answering **"yes"** to **three or more** of the 8 questions indicates that you are at **High Risk** for OSA. Answering **"yes"** to **less than three** questions indicates that you are at Low Risk for OSA. If you scored in the **High Risk for OSA** category, a **sleep study** or an **evaluation** by a **sleep specialist** may be warranted.

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SEDATION

How do you like your smile?

Are you happy with the appearance of your smile? ☐ Yes ☐ No

Are your teeth straight? ☐ Yes ☐ No

Do you like the color of your teeth? ☐ Yes ☐ No

Do you like the shape of your teeth? ☐ Yes ☐ No

Do you have old fillings that you don't like? ☐ Yes ☐ No

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

_____

_____

_____

Do you have any concerns that you would like to share? _____

_____

_____

_____ .

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

Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

This consent form allows Grand Dental Studio 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.

Grand Dental Studio 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 Grand Dental Studio.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Grand Dental Studio 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 Grand Dental Studio 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 Grand Dental Studio 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: _____

_____ Initial I hereby authorize Grand Dental Studio to use unsecured email and mobile phone text 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 Grand Dental Studio may leave messages on my voicemail to confirm appointments, and/or 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 Grand Dental Studio 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 Grand Dental Studio may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that Grand Dental Studio may disclose my personal health information to the following person(s).

Name	Telephone Number	Relationship to Patient

CLIENT PHOTO RELEASE FORM

I, _____, hereby authorize Grand Dental Studio to take photographs, x-rays, intra oral pictures, slides and /or videos of my facial area, jaws, teeth or anything in reference to my dental treatment.

I understand that these diagnostic tools will be used as a record of my care and may be used for educational purposes in lectures, demonstrations and advertising. Their use may include, but are not limited to, website publication, newspapers, magazines, phone books, television and professional (dental magazines and journals), videos and social media.

I also understand that if the photographs, x-rays, intra oral pictures, slides and/or videos of my facial area, jaws, teeth or anything in reference to my dental treatment are used in any type of marketing publication or as part of any presentation or demonstration, that my name or other identifying information may be used unless otherwise stated below. I do not expect compensation, financial or otherwise, for the use of photographs. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

PLEASE INITIAL:

____ I do not mind if my name and face are used in any of the above mentioned situations.

EXCEPTIONS:

____ I do not wish to have my name shown or released.

____ I do not wish to have my face shown.

Signature: _____ Date: _____

If patient is a minor:
Parent/Legal Guardian: _____ Date: _____

Signature: _____ Date: _____