OSHINS OF SMILES
Advanced Dentistry for Total Body Wellness

Patient Registration Form

Patient's Legal Name *

First Name | Middle Name | Last Name

Date of Birth *

Month | Day | Year

Sex *

Male | Female

Social Security Number *

Home Phone #

Prefer to Be Called

Cell Phone #

Email *

example@example.com

Marital Status *

Single | Married | Widowed | Divorced | Under Age 18

Patient's Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Patient/Guardian's Employer *

Occupation

Work Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Work Phone Number

Spouse's Name

First Name

Middle Name

Last Name

Spouse's Employer

Spouse's Occupation

Spouse's Work Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Spouse's Work Phone Number

Other Family Members That Are Patients Here

Who Can We Thank For Referring You To Our Office?

Emergency Contact Information

Person We May Contact in Case of An Emergency (Other Than Your Family Home)

Emergency Contact Name *

First Name Last Name

Relationship to Patient *

Home Phone Number

Area Code Phone Number

Cell Phone Number

Area Code Phone Number

Work Phone Number

Area Code Phone Number

Request for Confidential Communication

As My Dental Care Provider, You May Do The Following With My Permission

	Yes	No
Contact Me At Home	○	○
Contact Me Via Cell Phone	○	○
Contact Me At Work	○	○
Contact Me Via Email	○	○
Leave Messages On My Home Voicemail/Answering Machine	○	○
Leave Messages On My Cell Phone Voicemail	○	○
Leave Messages On My Work Voicemail/Answering Machine	○	○

Insurance and Financial Information

Insurance Company Name

Insurance Phone Number *

Insurance Company Name *

Subscriber's SSN/ID# *

Insurance Address *

Street Address

Street Address Line 2

City State

Zip Code

Group/Program Number *

Subscriber's Birthday *

Month Day Year

Subscriber's Name *

First Name Last Name

Patient's Relationship to Subscriber *

Self Spouse Dependent

Employer's Address

Street Address

Street Address Line 2

City State

Zip Code

Employer (If Different from Above)

Release Information

You May Discuss My Healthcare With:

Health Care Providers *

- ○ Yes
- ○ No

Insurance Companies *

- ○ Yes
- ○ No

Others (Enter Below)

Confirmations

Do You Prefer a Confirmation Call? *

- ○ No, It is unnecessary
- ○ Yes, It is a helpful reminder

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due to and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations, and/or presentations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature

_____

Date *

Month Day Year

Consent of Treatment

1.

I hereby authorize Doctor Oshins or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.

2.

Upon such diagnosis, I authorize Doctor Oshins to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% (18% APR) may be added to my account. I also agree to pay any legal interest on the balance due together with any collection costs and attorney fees incurred in the attempt of collection of this account.

Signature

Date *

Month Day Year

Relationship to Patient

HIPPA Consent Form

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Oshins of Smiles may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Oshins of Smiles has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practice.

I hereby acknowledge that I received a copy of Oshins of Smiles Notice of Privacy Practices.

Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to:

Name

Relationship

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by Oshins of Smiles to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes releasing of the information to the insurer or agency given to Oshins of Smiles for participating health insurance plans.

Signature

Date *

Month Day Year

Medical History

Patient Name *

First Name Middle Name Last Name

Nickname

Age *

Name of Physician/and their specialty *

Date of most recent physical examination *

Month Day Year

Purpose of most recent physical examination *

What is your estimate of your general health? *

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you ever had an allergic or bad reaction to any of the following:

	Yes	No
Aspirin, Ibuprofen, Acetaminophen, Codeine	○	○
Penicillin	○	○
Erythromycin	○	○
Tetracycline	○	○
Sulfa	○	○
Local Anesthetic	○	○
Fluoride	○	○
Chlorhexidine (CHX)	○	○
Metals (nickle, gold, silver, other metals)	○	○
Latex	○	○
Nuts	○	○
Fruit	○	○

Any other allergic or bad reaction items that we should know about?

Do You Have or Have You Ever Had:

	Yes	No
Hospitalization for illness or injury	○	○
Heart problems or cardiac stent within the last 6 months	○	○
History of infective endocarditis	○	○
Artificial heart valve, repaired heart defect (PFO)	○	○
Pacemaker or implantable defibrillator	○	○
Orthopedic implant (joint replacement)	○	○
Rheumatic or scarlet fever	○	○
High or low blood pressure	○	○
A stroke (taking blood thinners)	○	○
Anemia or other blood disorder	○	○
Prolonged bleeding due to a slight cut (INR >3.5)	○	○
Pneumonia, emphysema, shortness of breath, sarcoidosis	○	○
Chronic ear infections, tuberculosis, measles, chicken pox	○	○
Asthma	○	○
Breathing or sleep problems (e.g. sleep apnea, snoring, sinus)	○	○
Kidney disease	○	○
Liver disease	○	○
Jaundice	○	○
Thyroid, parathyroid disease, or calcium deficiency	○	○
Hormone deficiency	○	○
High cholesterol or taking statin drugs	○	○
Diabetes	○	○
Stomach or duodenal ulcer	○	○
Digestive or eating disorders	○	○
Osteoporosis/osteopenia (e.g. taking bisphosphonates)	○	○

Arthritis	○	○
Autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	○	○
Glaucoma	○	○
Contact lenses	○	○
Head and neck injuries	○	○
Epilepsy, convulsions (seizures)	○	○
Neurologic disorders (ADD/ADHD, prion disease)	○	○
Viral infections and cold sores	○	○
Any lumps or swelling in the mouth	○	○
Hives, skin rash, hay fever	○	○
STI/STD/HPV	○	○
Hepatitis A	○	○
Hepatitis B	○	○
Hepatitis C	○	○
Hepatitis D	○	○
Hepatitis E	○	○
HIV/AIDS	○	○
Tumor, abnormal growth	○	○
Radiation therapy	○	○
Chemotherapy, immunosuppressive medication	○	○
Emotional difficulties	○	○
Psychiatric Treatment	○	○
Antidepressant Medication	○	○
Alcohol/ recreational drug use	○	○

Are You:

	Yes	No
Presently being treated for any other illness	○	○
Aware of a change in your health in the last 24 hours (e.g. fever, chills, new cough, or diarrhea)	○	○
Taking medication for weight management	○	○

Taking dietary supplements	○	○
Often exhausted or fatigued	○	○
Experiencing frequent headaches	○	○
A smoker, smoked previously or use smokeless tobacco	○	○
Consider a touchy/sensitive person	○	○
Often unhappy or depressed	○	○
Taking birth control pills	○	○
Currently pregnant	○	○
Diagnosed with a prostate disorder	○	○

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
1.		
2.		
3.		
4.		
5.		
6.		

Signature

Date *

Month Day Year

Dental History

Patient Name *

First Name Last Name

Nickname

Age *

Patient Email *

example@example.com

Referred By

How would you rate the condition of your mouth? *

- Excellent
- Good
- Fair
- Poor

Previous Dentist

How long have you been a patient (in months/years)?

Date of your most recent dental exam *

Month Day Year

Date of most recent treatment (other than a cleaning) *

Month Day Year

Date of most recent x-rays *

Month Day Year

I routinely see my dentist every *

- 3 months
- 4 months
- 6 months
- 12 months
- Not routinely

What is your immediate concern? *

Please Answer Yes or No to the Following:

Personal History

	Yes	No
Are you fearful of dental treatment?	○	○
Have you had an unfavorable dental experience?	○	○
Have you ever had complications from past dental treatment?	○	○
Have you ever had trouble getting numb or had any reactions to local anesthetic?	○	○
Did you ever have braces, orthodontic treatment, or had your bite adjusted?	○	○
Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	○	○

At what age did you have braces, orthodontic treatment, or your bite adjusted (if any)?

How fearful of dental treatment are you?

	1	2	3	4	5	6	7	8	9	10	
Least	○	○	○	○	○	○	○	○	○	○	Most

Gum and Bone

	Yes	No
Do your gums bleed or are they painful when brushing or flossing?	○	○
Have you ever been treated for gums disease or been told you have lost bone around your teeth?	○	○
Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
Is there anyone with a history of periodontal disease in your family?	○	○
Have you ever experienced gum recession?	○	○
Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?	○	○
Have you experienced a burning or painful sensation in your mouth not related to your teeth?	○	○

Tooth Structure

	Yes	No
Have you had any cavities within the past 3 years?	○	○
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?	○	○
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	○	○
Do you have grooves or notches on your teeth near the gum line?	○	○
Have you ever broken teeth, chipped teeth, or had toothache or cracked filling?	○	○
Do you frequently get food caught between any teeth?	○	○

Bite and Jaw Joint

	Yes	No
Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)	○	○
Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	○	○
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	○	○
In the past 5 years, have your teeth changed (becomes shorter, thinner, or worn) or has your bite changed?	○	○
Are your teeth becoming more crooked, crowded, or overlapping?	○	○
Are your teeth developing spaces or becoming more loose?	○	○
Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	○	○
Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
Do you clench or grind your teeth together in the daytime or make them sore?	○	○
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	○	○
Do you wear or have you ever worn a bite appliance?	○	○

Smile Characteristics

	Yes	No
Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	○	○
Have you ever whitened (bleached) your teeth?	○	○
Have you felt uncomfortable or self conscious about the appearance of your teeth?	○	○
Have you been disappointed with the appearance of the previous dental work?	○	○

Signature

_____

Date *

Month Day Year

Sleep Apnea Patient Questionnaire

Name *

First Name | Middle Name | Last Name

Date *

Month | Day | Year

STOP-BANG Patient Questionaire

Please answer the questions below to help us see if you might have sleep apnea. This is when your breathing pauses sometimes while you are sleeping.

*

	Yes	No
SNORING - Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
TIREDNESS/FATIGUE - Do you often feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep?	○	○
OBSERVED APNEA - Has anyone ever observed you to stop breathing during your sleep?	○	○
PRESSURE - Do you have or are you being treated for high blood pressure?	○	○
BODY MASS INDEX - More then 35? (BMI Formula: weight (lb) / Height (in)2 x 703)	○	○
AGE - Are you older than 50 years?	○	○
NECK SIZE - Does your neck measure more than 15 ¾ inches (40 cm) around?	○	○
GENDER - Are you male?	○	○

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of medicine as a subjective measure of a patient's sleepiness. How likely are you to dose off or fall asleep during the following situations, in contrast to just feeling tired?

For each of the situations listed below, select a score of 0 to 3

0 = *Would never doze*; 1 = *Slight chance of dozing*;

2 = *Moderate chance of dozing*; 3 = *High chance of dozing*

	0	1	2	3
Sitting and Reading	○	○	○	○
Watching Television	○	○	○	○
Sitting inactively in a public place (for example a theater or meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch (when you've had no alcohol)	○	○	○	○
In a car, when stopped in traffic	○	○	○	○

Total Epworth Score

Appointment Policy

Welcome to Oshins of Smiles! We appreciate your decision to come to us for your dental needs.

As a patient, it is important that you understand our commitment to providing timely and quality service to all of our patients. An important aspect of this service is the commitment of each patient to honor their appointment by both showing up in a timely manner, as well as giving proper notice if they are unable to keep their scheduled appointment. We ask that, whenever possible, you provide us with 48 business hours notice for appointments that you cannot keep. Missed appointments increase the cost of healthcare for everyone. Unless an emergency, cancellations or appointment changes made with less than 48-hours notice will incur a fee.

We do require a credit card to be held on file to reserve any longer appointment with Dr. Oshins, which will only be processed if you cancel without proper notice. Please note, cancellations made on Fridays, Saturdays or Sundays are not accepted as 48-hours notice. We appreciate your cooperation in arriving promptly for scheduled appointments.

I have read, understand the appointment policy. Please initial below:

Signature

_____

Date *

Month Day Year

Oshins of Smiles Financial Policy

Our office is committed to providing you with the best possible dental care. If you have dental insurance, we are happy to you help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly answer any questions relating to your insurance. Your insurance is a contract between you, your employer, and your insurance company. Not all services are covered benefits in all contracts. There are some procedures insurance companies do not cover. Insurance companies rarely reimburse the full amount of restorations, or major procedures. Generally they pay 50% to 80% of the fee.

We are happy to file all insurance claims for you. Our filing the claim on your behalf does not guarantee payment nor does a pre-determination of benefits represent a guarantee of payment. Our office will estimate what your portion will be based on information we have available to us, any balance is expected in full at time of service. Some insurance companies pay the patient directly and in turn we ask that you pay the entire amount at time of service. Any balance not paid by the insurance company is solely your responsibility.

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. While the filing of insurance claims for dental charges is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

Any account with an outstanding balance that has not been paid in full within 90 days will be considered delinquent and will be referred to an outside agency for collection. If an account is sent to this agency, the patient or patient's guarantor will bear the responsibility of any fees involved in collection on that account.

If you have any questions about the above information, please don't hesitate to ask us.

Signature

_____

Date *

Month Day Year