PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME	LAST,	FIRST	MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS	STREET	APT#	CITY	STATE	ZIP	E-MAIL

MARITAL STATUS ☐ ☐ ☐ ☐ ☐	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS	STREET	APT#	CITY	STATE	ZIP	WORK PHONE #

SPOUSE'S NAME	LAST,	FIRST	MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS	STREET	APT#	CITY	STATE	ZIP	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
☐ YES ☐ NO			
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
☐ YES ☐ NO			
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	☐	☐	1.
Insurance Companies	☐	☐	2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

SIGNATURE - GUARANTOR OF PATIENT	DATE

OSHINS OF SMILES
Advanced Dentistry for Total Body Wellness

Consent for 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 (name of patient) _____ '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 even 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.

Patient's Signature: _____ Date: _____

Parent/Responsible Party's Signature _____ Relationship to patient _____

Appointment Policy

Welcome to OshinsofSmiles! 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 and agree to honor the appointment agreement as mentioned above.

Patient Signature _____
Date _____

OSHINS OF SMILES
FAMILY, AESTHETIC DENTISTRY AND DENTAL SLEEP MEDICINE

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 for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ 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. orthopedic implant (joint replacement) _____	☐	☐
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. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (e.g., 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 ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. 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	Drug	Purpose

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 _____

ASA _____ (1-6)

© 2018 Kois Center, LLC

OSHINS OF SMILES
FAMILY, AESTHETIC DENTISTRY AND DENTAL SLEEP MEDICINE

DENTAL HISTORY

Patient name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/___

Date of most recent treatment (other than a cleaning) ___/___/___

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		**YES**	**NO**
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		**YES**	**NO**
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		**YES**	**NO**
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	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?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		**YES**	**NO**
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

© 2018 Kois Center, LLC

OSHINS OF SMILES
FAMILY, AESTHETIC DENTISTRY AND DENTAL SLEEP MEDICINE

Dentistry for Total Body Wellness

Your Solution for Dental Wellness, Health, Comfort & Beauty

Last Name _____ **First Name** _____ **Date** _____

STOP-BANG Patient Questionnaire

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.

	Y	N
1. **Snoring**: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐	☐
2. **Tiredness/fatigue**: Do you often feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep?	☐	☐
3. **Observed Apnea**: Has anyone ever observed you to stop breathing during your sleep?	☐	☐
4. **Pressure**: Do you have or are you being treated for high blood pressure?	☐	☐
5. **Body Mass Index**: More then 35? BMI Formula: weight (lb) / Height (in)2 x 703	☐	☐
6. **Age**: Are you older than 50 years?	☐	☐
7. **Neck size**: Does your neck measure more than 15 ¾ inches (40 cm) around?	☐	☐
8. **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 doze off or fall asleep during the following situations, in contrast to just feeling tired?

For each of the situations listed below, give yourself a score of 0 to 3
***0**= Would never doze; **1**= Slight chance; **2**= Moderate chance; **3**=High chance*

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

For office use only
M: _____
S: _____
T: _____

Total Score: _____

OSHINS OF SMILES
FAMILY, AESTHETIC DENTISTRY AND DENTAL SLEEP MEDICINE

HIPAA 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.

_____
Initials of Patient/Guardian

Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to:

_____ _____
Name **Relationship**

_____
Initials of Patient/Guardian

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 of Patient/Guardian **Date**

OSHINS OF SMILES
FAMILY, AESTHETIC DENTISTRY AND DENTAL SLEEP MEDICINE

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** _____

OSHINS OF SMILES
FAMILY, AESTHETIC DENTISTRY AND DENTAL SLEEP MEDICINE

Pediatric Sleep Questionnaire

(Screening for Snoring, Sleepiness, and Behavioral Problems)

Patient Name: _____ **DOB:** _____ **Date:** _____

	Yes	No	Don't Know
While sleeping, does your child...			
have trouble breathing or struggle to breath?			
stop breathing during the night?			
have "heavy" or loud breathing?			
snore regularly?			
snore more than half the time?			
appear to be a restless sleeper?			
child kick during sleep?			
have nightmares?			
scream in their sleep?			
grind their teeth during sleep?			
sleepwalk?			
occasionally wet the bed?			
Upon awakening, does your child...			
have a dry mouth in the morning?			
tend to breathe through the mouth during the day?			
wake up feeling un-refreshed in the morning?			
have a problem with sleepiness during the day?			
have trouble getting going in the morning?			
wake up with headaches in the morning?			
We have noticed that our child...			
does not seem to listen when spoken to directly			
has difficulty organizing tasks			
is easily distracted by extraneous stimuli			
fidgets with hands or feet or squirms in seat			
interrupts or intrudes on others (e.g. butts into conversations or games)			
has a teacher or other supervisor comment that your child appears sleepy during the day			
has been diagnosed with ADD or ADHD			
Additionally...			
did your child stop growing at a normal rate at any time since birth?			
is your child overweight?			
does your child's teeth seem crooked or misaligned?			
does your child have allergies?			
does your child have frequent colds?			
does your child have difficulty with pronunciation?			

Total Number of "Yes" Responses _____

If eight or more statements are answered "yes", consider referring for sleep evaluation

For office use only

M_____

S _____

T _____

OSHINS OF SMILES
Advanced Dentistry for Total Body Wellness

Authorization to Release Dental Information

I request and authorize Dr/Office: _____

Phone# _____ Fax# _____

Email address: _____

To release a copy of my dental chart and dental x-rays to:

Dr. Steven Oshins via email: Info@oshinsofsmiles.com

Patient Name: _____ DOB _____

_____ _____

Signature Date

3905 Carman Road Schenectady, New York 12303
Office: 518.356.5635 **Fax**: 518.356.5675 **Email**: Info@oshinsofsmiles.com