

1 PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____
LEGAL Name

Wished to be called _____

Responsible Party _____
Name/Relationship

Address _____

City _____

State _____ Zip _____

Sex M F

Birth date _____ Age _____

Married Widowed Single

Minor Separated Divorced

Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

Spouse's Social Security # _____

Spouse's Employer _____

How did you hear about our office?

2 INSURANCE INFORMATION

WE WILL NEED TO COPY INSURANCE CARDS AND LICENSE DENTAL INSURANCE: (1-Primary 2-Secondary)

1) Subscriber's Name _____

Subscriber's Birth date _____

Subscriber's ID or SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

2) Subscriber's Name _____

Subscriber's Birth date _____

Subscriber's SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by medical insurance? Yes No

Subscriber's Name _____

Subscriber's Birth date _____

Subscriber's SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I understand that Dr. Stephen E. Burch does not participate with any insurance companies, all claims will be submitted as a courtesy on my behalf, and that reimbursements will come to me directly from the insurance company. This EXCLUDES Medicare and Supplemental policies. **We do NOT participate with Medicare.** ___

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

___ I have read and agree to the HIPAA acknowledgement

Signature of Patient, Parent, Guardian or Personal Representative Date

3 CONTACT INFORMATION

Home (____) _____

Work (____) _____ Ext _____

Cell Phone (____) _____

E-mail Address _____
Used for Confirming Appointments

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

4

DENTAL INTERVIEW

Fear, Trust, Time, Money, Urgency

D I S C

Date of Last Dental Visit _____

Reason for Today's Visit _____

How long would you like to keep your teeth? _____

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

What would you change? _____

Does your mouth function properly? Yes No

Are you fearful? Yes No Rate your fear level 1-10 _____

Reason for the fear? Needles Smell Sound Fear of Pain GS Triaz Both

Did you have any financial concerns? Yes No

If financing, would you need a co-signer? Yes No

Do you know we offer financing for qualified patients? Yes No

What are your other financial concerns? _____

Special time frames? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Clenching teeth Yes No

Clicking or popping jaw Yes No

Fingernail biting Yes No

Grinding teeth Yes No

Headaches/migraines Yes No

Lip or cheek biting Yes No

Braces -when _____ Yes No

Pain around ear Yes No

Sensitivity to biting Yes No

Sensitivity to hot, cold, sweets Yes No

Vertigo (dizziness) Yes No

Ringing in the ears Yes No

Postural Problems Yes No

Cervical pain(upper neck) Yes No

Paresthesia of fingertips (Tingling) Yes No

Tingling in jawbone Yes No

Jaw pain or tiredness Yes No

Numbness in jawbone Yes No

Numbness in lower lip Yes No

Limited opening Yes No

Pain when swallowing Yes No

Poorly fitting upper appliance Yes No

Bell's Palsy Yes No

Nervousness/Insomnia Yes No

Facial or Trigeminal Neuralgia Yes No

Nutritional disorder Yes No

Digestive problems Yes No

Bleeding gums Yes No

Have your gums receded? Yes No

Do you have swollen or infected gums, or bad breath? Yes No

Food collection between teeth Yes No

Loose teeth Yes No

Have you had teeth extracted? Yes No

Why: _____

Diet limited to liquid foods Yes No

Difficulty chewing Yes No

Difficulty swallowing Yes No

Difficulty speaking Yes No

Gagging easily Yes No

Dry mouth Yes No

Mouth breathing Yes No

Blisters on lips or mouth Yes No

Do you floss Yes No

How often? _____

Patient Signature: _____ Date: _____

5 Health History

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	—Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Legs Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
ANEMIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High / Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	
		Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Height: _____ Weight: _____

- Yes No Do you use recreational drugs? What? _____
- Yes No Do you use tobacco products? If yes, what and how often, how long? _____
- Yes No Do you take pain relievers? What and how often? _____
- Yes No Do you use antidepressants or sleeping pills? What and how often? _____
- Yes No Are you on any blood thinners, including aspirin? mg _____

Sleep Apnea Yes No (C Pap) Yes No Have you had sleep studies Yes No
Do you Snore Yes No

Are you currently taking or have you taken any of the following medications?

- Alendronate-Fosomax-oral Yes No
- Ibandronate-Boniva-oral Yes No
- Risedronate-Actonel—oral Yes No

WOMEN:

- Are you pregnant?
 Yes No If yes when is your due date? _____
- Taking birth control pills? Yes No
- Are you taking hormones? Yes No

FAMILY HISTORY Has any member of your family had the following and if so who (Grandparent, Parent, Sibling, etc)

- | | | | |
|------------------------|------------|-----------------------|------------|
| ____ Cancer | Who: _____ | ____ Obesity | Who: _____ |
| ____ Heart Disease | Who: _____ | ____ Thyroid Disorder | Who: _____ |
| ____ Diabetes | Who: _____ | ____ Snores | Who: _____ |
| ____ High Bl. Pressure | Who: _____ | ____ Wears CPAP | Who: _____ |
| ____ Stroke | Who: _____ | ____ Sleep Apnea | Who: _____ |
| ____ Sleep disorder | Who: _____ | ____ Deceased Age | Who: _____ |

MEDICATIONS	ALLERGIES										
List medications, dosages, reason for taking medication: _____ _____ Vitamins, minerals, herbs: _____	<table border="0" style="width: 100%;"> <tr> <td>____ Aspirin</td> <td>____ Local Anesthetic</td> </tr> <tr> <td>____ Barbiturates (sleeping pills)</td> <td>____ Penicillin</td> </tr> <tr> <td>____ Codeine</td> <td>____ Sulfa</td> </tr> <tr> <td>____ Iodine</td> <td>____ Latex</td> </tr> <tr> <td>____ Other _____</td> <td>____ NONE</td> </tr> </table>	____ Aspirin	____ Local Anesthetic	____ Barbiturates (sleeping pills)	____ Penicillin	____ Codeine	____ Sulfa	____ Iodine	____ Latex	____ Other _____	____ NONE
____ Aspirin	____ Local Anesthetic										
____ Barbiturates (sleeping pills)	____ Penicillin										
____ Codeine	____ Sulfa										
____ Iodine	____ Latex										
____ Other _____	____ NONE										

7

RATE YOUR SYMPTOMS

Name: _____ Date: _____

Date of Birth: _____ Male _____ Female _____

CHOOSE THE SYMPTOMS BELOW THAT APPLY TO YOU AND RATE THEM IN ORDER OF SEVERITY BEGINNING WITH NUMBER ONE.

TMD/PAIN COMPLAINTS

- ___ Back pain
- ___ Difficulty swallowing
- ___ Dizziness
- ___ Ear congestion
- ___ Ear pain
- ___ Facial pain
- ___ Headaches
- ___ Migraines
- ___ Jaw clicking/popping
- ___ Jaw joint noises
- ___ Jaw locking
- ___ Jaw pain
- ___ Limited mouth opening
- ___ Morning head pain
- ___ Muscle twitching
- ___ Neck pain
- ___ Nocturnal teeth grinding
- ___ Pain when chewing

SLEEP/BREATHING COMPLAINTS

- ___ CPAP Intolerance
- ___ Difficulty falling asleep
- ___ Fatigue
- ___ Feeling unrefreshed upon waking
- ___ Frequent heavy snoring
- ___ Frequent heavy snoring which
which affects others
- ___ Gasping when waking up
- ___ Morning hoarseness
- ___ Nighttime choking spells
- ___ Significant daytime drowsiness
- ___ Sleepy while driving
- ___ Swelling in ankles or feet
- ___ Witnessed apneic events

Patient Signature _____

CONSENTS: Please INITIAL and SIGN below.

_____ I hereby authorize Dr. Stephen E. Burch and/or his staff to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, and demonstrations by Dr. Burch and/or his staff.

_____ I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. Burch and/or his staff for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand I will receive no further financial compensation for the use, at any time in the future, of my testimonials, photos, slides, or videos by Dr. Burch and his staff.

_____ I hereby give a limited duration of health care power of attorney to (name) _____ of (address) _____ and (phone) _____ my (relationship) _____ and by so doing, I hereby give my permission and consent for them to make treatment decision(s), including surgery and medication, on my behalf during my sedation visit(s). I hereby ratify and confirm all that my attorney shall do or cause to be done by virtue of this health care power of attorney and the rights and powers granted herein. Upon conclusion of my sedation treatment with Dr. Burch then this health care power of attorney shall be considered revoked.

_____ I understand that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable before the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

_____ Pursuant to Virginia Law 32.1-45.1 – Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus(HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

_____ You must provide us with **48 business hours** advance notice for any cancellations of any of your appointments in order to avoid the imposition of cancellation fees, which are determined by the length and type of service being rendered at the scheduled visit. Such cancellation fees are **non-refundable**.

_____ I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice, and I received a copy of this agreement simultaneously upon my endorsing it.

*******DO NOT SIGN UNLESS YOU'VE READ AND UNDERSTOOD*******

Patient or Responsible Party _____ Date _____

Services

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> SLEEP BREATHING DISORDERS | <input type="checkbox"/> IMPLANT SERVICES | <input type="checkbox"/> "FACE LIFT" DENTURES | <input type="checkbox"/> ORAL SURGERY |
| <input type="checkbox"/> COMPREHENSIVE DENTAL | <input type="checkbox"/> TREATMENT FOR TMJ, | <input type="checkbox"/> PERIODONTAL THERAPY | <input type="checkbox"/> ENDODONTIC THERAPY |
| <input type="checkbox"/> NEUROMUSCULAR/ | HEAD, NECK AND | <input type="checkbox"/> RECONSTRUCTIVE/ | <input type="checkbox"/> CONSCIOUS SEDATION |
| ORTHOPEDIC DENTISTRY | FACE PAIN | AESTHETIC DENTISTRY | <input type="checkbox"/> GENERAL ANESTHESIA |