PARK DENTAL WELLNESS

COMPASSIONATE AND COMPREHENSIVE CARE

Patient Information

Patient Name: ______________________________DOB __________ SS#___________________

Address: ______________________________ City/State/Zip ___________________________

Your Home Phone# (___)_________________ Your Cell # ______________________________

Your E-Mail Address ____ Do you text? __________

If the above is a minor, who is the responsible party?__________________________________

Whom may we thank for inviting you to our office? ____________________________________

Primary Insurance Information:

Name: ________________________DOB:_____________SSN#:___________________________

Relationship to Patient _______________Work#: (___)_______________Cell _______________

Email ______________________________Employer: __________________________________

Dental Ins: ___________________________ Insurance ID #:_____________________________

Secondary Insurance Information:

Name: ________________________DOB:_____________SSN#:___________________________

Relationship to Patient _______________Work#: (___)_______________Cell _______________

Email ______________________________Employer: __________________________________

Dental Ins: ___________________________ Insurance ID #:_____________________________

I understand and agree that, (regardless of my insurance status) I am responsible for the balance on my account for any professional services rendered. I have read all of the information on this form and have completed the above questions. I certify this information is correct and I will notify you of any changes in my health status or the above information

_________________________ _______________________

Signature Date

Total Wellness Screening

At Park Dental Center, we are devoted to helping you establish your teeth and bite in optimum health, for a lifetime. We are equally committed to your whole health.

Please circle the answer that best describes you.

Do you have a family history of heart disease or strokes? **YES** **NO**

Do you have a family history of Type II diabetes? **YES** **NO**

Periodontal Pathogens (harmful oral bacteria):

Studies show that harmful bacteria in the mouth are a primary cause of tooth decay, bleeding gums, periodontal disease, tooth loss, and body-wide inflammation.

Have either of your parents or siblings lost their teeth or been diagnosed with periodontal disease? **YES** **NO**

Do your gums bleed easily? **YES** **NO**

Nutrition:

Studies show that whole fruits and veggies strengthen bone, gums, and teeth.

Approximately how many servings (cups) do you eat each day? **0-2** **3-4** **>4**

Studies show that refined foods containing sugar, flour, and white rice weaken bone, gums, and teeth. This includes sodas/diet sodas, energy drinks, juices, breads, fried foods, and processed snacks (chips, candy).

Approximately how many servings (cups) do you ingest each day? **0-2** **3-4** **>4**

Physical Activity:

Studies show that physical activity is critical to total wellness and that physical inactivity is "the biggest public health issue of the 21st century"

How physically active are you?

1. **VERY** – I purposefully exercise several times every week
2. **SOMEWHAT** – I try to exercise when I can.
3. **NOT VERY** – I wish I were!

Toxins Exposure

Studies show that toxins, such as tobacco and mercury overexposure (fish), are significant risk facts for body-wide inflammation.

Do you smoke or chew tobacco? **YES** **NO**

Do you eat largemouth fish (bass, tuna, grouper, etc) more than once/week? **YES** **NO**

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Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City:
State:
Zip:

Occupation:
Height:
Weight:
Date of Birth:
Sex: M F

SS# or Patient ID:
Emergency Contact:
Relationship:
Home Phone: *Include area code* ( )
Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name:
Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Form S500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) — Yes / No / DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ____________ If yes, have you had any complications? ____________

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began: ____________

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ____________
If yes, how much do you typically drink i n a week? ____________

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: ____________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics ____	☐	☐	☐
Aspirin ____	☐	☐	☐
Penicillin or other antibiotics ____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____	☐	☐	☐
Sulfa drugs ____	☐	☐	☐
Codeine or other narcotics ____	☐	☐	☐
Metals ____	☐	☐	☐
Latex (rubber) ____	☐	☐	☐
Iodine ____	☐	☐	☐
Hay fever/seasonal ____	☐	☐	☐
Animals ____	☐	☐	☐
Food ____	☐	☐	☐
Other ____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion (If yes, date: ____)	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders (If yes, specify: ____)	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders (Specify: ____)	☐	☐	☐
Recurrent Infections (Type of infection: ____)	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Adult Airway Questionnaire/ Epworth Sleepiness Scale

PATIENT NAME:_____________________________________ **DATE**:_____________________

Please fill out this form as accurately and honestly as possible. Dr. Park understands the importance of breathing and the form and function of the upper airway that affect your total health and wellness. It is documented that the mildest form of Sleep Disorder Breathing, and or SNORING can impair neurobehavioral development. Based on the wellness model, our team will evaluate your body as a whole, treat the underlying causes, restore your body's optimal breathing, sleep habits, improve your overall health and elevate your quality of life.

Please us the scale to determine your level of sleepiness; Choose the most appropriate number for each situation:

0= no chance of dozing
1= slight chance of dozing
2=moderate chance of dozing or sleeping
3= high chance of dozing or sleeping

SITUATION	CHANCE OF DOZING OR SLEEPING
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a motor vehicle for an hour or more	
Lying down to rest in the afternoon when circumstances permits	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score (This is your Epworth score)	

Please circle which applies to you:

1. Do you breathe through your mouth?
2. Do you frequently get a dry throat or non-productive cough?
3. Do you have any nasal allergies?
4. Do you snore or have ever been told you snore while sleeping?
5. Do you stop or pause your breathing while sleeping?
6. Do you wake up fatigued?
7. Do you have morning tension or migraine headaches?
8. Do you easily get tired or fall asleep during the day?
9. Do you clench or grind your teeth during the night?
10. Do you clench or grind your teeth during the day?
11. Do you have any facial pain?
12. Do you usually drink alcohol or take sleep aids before going to bed?
13. Do you suffer from hypertension?
14. Have you been diagnosed with Chronic Fatigue Syndrome, Irritable Bowel Syndrome, Fibromyalgia or Temporomandibular Syndrome?

Linda Park, D.D.S., 4300 East Court St, Burton, MI 48509, Phone: 810-742-5140,Fax: 810-742-6650
Email: parkdentalfrontdesk@gmail.com