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 Wellness, 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 <u>circle the answer</u> 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**

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

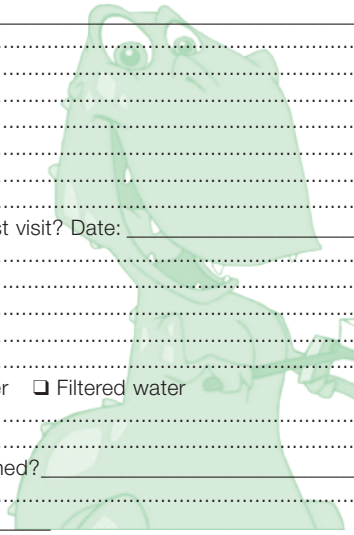
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



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. 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.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accounting Act of 1996 (HIPPA) requires that this office comply with certain rules regarding the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPPA's requirements we have copies of our Notice of Privacy Practices in the office for your review. This Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices.

Existing Michigan law requires us to first obtain your written consent prior to disclosing any of your information except for your disclosures in connections with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

I acknowledge that I have today received and/or had access to a copy of the Notice of Privacy Practices. I consent to your disclosure of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

X_____ _____

Patient/Parent Signature Patient Name (Please Print)

I am also signing for my minor children (please list names)_____

_____

I ALSO GIVE CONSENT FOR MY TREATMENT TO BE DISCUSSED WITH THE FOLLOWING INDIVIDUALS: (spouse, parent, adult child, caregiver, etc.)

X _____

(Please Print Names)

X_____

(Date)

Authorization

I hereby certify that I have read and understood the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect/inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health I will inform the office at my next dental appointment without fail.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I also authorize Park Dental Center, Linda M Park, to use my likeness in a photograph and/or x-rays in all publications including but not limited to printed and digital publications and advertisements. I acknowledge that I will receive no compensation for the use of my likeness.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on the behalf of my dependents (if any) and/or anyone covered on my insurance. I understand that I will be charged .58% interest month (7% annually) on balances over 90 days old.

I have been informed and agree that I will be charged a $40.00 fee for appointments cancelled with less than 48 hours' notice.

Signature of patient, parent, or guardian: _____

Printed Name: _____ Date:_____

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Pediatric Airway Questionnaire

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.

PATIENT NAME:_____ **DATE**:_____

Please check all that apply:

___While sleeping, does your child snore more than half of the time?

___While sleeping, does your child always snore?

___While sleeping, does your child snore loudly?

___While sleeping, does your child have "heavy" or loud breathing?

___While sleeping, does your child have trouble breathing, or struggle to breathe?

___Has your child ever stopped breathing at night?

___Does your child occasionally wet the bed, sleepwalk, or have night terrors? (Circle any that apply)

___Does your child tend to breathe through their mouth during the day?

___Does your child have a dry mouth on waking in the morning?

___Does your child wake up unrefreshed in the morning?

___Does your child wake up with headaches in the morning?

___ Is it hard to wake up your child in the morning?

___ Does your child have a problem with sleepiness during the day?

___Has a teacher or supervisor commented – your child appears sleepy during the day?

___Did your child stop growing at a normal size since birth?

___Is your child overweight?

___ Does your child not seem to listen when spoken to?

___Does your child often have difficulty organizing tasks and activities?

___Is your child easily distracted by extraneous stimuli?

___Does your child often fidget with their hands or feet, or squirm in their seat?

___Is your child often "on the go" or acts as if "driven by a motor"

___Does your child often interrupts or intrudes on others? (butts in conversations or games)

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