Maribel M. Vann, D.D.S.
Health Focused And Minimally Invasive Dentistry
• Treatment Of TMJ Disorder

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WELCOME TO OUR PRACTICE

We appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us and we will be more than happy to help.

ABOUT YOU

Today's date: _____ Sex: ″ M ″ F

Full Name: _____

Marital Status: _____ Birth Date: _____ Age: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Work: _____ Mobile: _____ Email: _____

Employer: _____ Employer's Address: _____

Occupation: _____

Whom do we thank for referring you? _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN YOURSELF)

Name: _____ Relationship: _____

Billing Address: _____

Home Phone: _____ Work Phone: _____ SS#: _____

Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

His/her Name: _____ Birth Date: _____ SS#: _____

Employer: _____ Work Phone: _____ Ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Group/Policy #:_____

Insurance Co. Address: _____

Insurance Phone #: _____

Insured's Name: _____ Insured's SS# _____

Insured's Birth Date: _____ Relation: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance

Insurance Co. Name: _____ Group/Policy #:_____

Insurance Co. Address: _____

Insurance Phone #: _____

Insured's Name: _____ Insured's SS# _____

Insured's Birth Date: _____ Relation: _____

Insured's Employer: _____ Employer's Address: _____

DENTAL INSURANCE INFORMATION

Name of Physician: _____ Phone: _____

Do you have or ever had any of the following? PLEASE check those that apply:

- ″ Allergies / Hay Fever
- ″ Anemia
- ″ Angina
- ″ **Artificial Joints ***
- ″ **Artificial Heart Valves***
- ″ Asthma
- ″ Arthritis
- ″ Chemical Dependency
- ″ Chemotherapy
- ″ Cancer
- ″ Diabetes
- ″ Emphysema
- ″ Epilepsy or Seizures
- ″ Excessive Thirst
- ″ Fainting or Dizziness
- ″ Fever/Blister/Cold Sores
- ″ Frequent Cough
- ″ Glaucoma
- ″ **Heart Disorder (Congenital)***
- ″ **Heart Infection***
- ″ **Heart Pace Maker***
- ″ **Heart Murmur***
- ″ **Heart surgery***
- ″ Hepatitis
- ″ High Blood Pressure
- ″ **HIV / AIDS***
- ″ Kidney Problems
- ″ Liver Problems
- ″ Mental Disorder
- ″ **Mitral Valve Prolapse***
- ″ Radiation Treatment
- ″ Respiratory Problems
- ″ Rheumatic Fever
- ″ Rheumatism
- ″ Sickle Cell Disease
- ″ Sinus Problems
- ″ **Stents (Location)***
- ″ **Surgical Shunt***
- ″ Thyroid Problems
- ″ Tuberculosis
- ″ Ulcers
- ″ Venereal Disease

***This condition may require antibiotic Premedication for certain dental procedures.**

- Do you have any health problems that were not listed above or need further clarification? ″ Yes ″ No

If yes, please explain: _____

- Are you now under the care of a physician? ″ Yes ″ No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ″ Yes ″ No

If yes, please explain: _____

- Are you taking any medications? ″ Yes ″ No

If yes, please explain: _____

- Are you allergic to any medications or substances? ″ Yes ″ No

If yes, please explain: _____

- Are you using or have you used Tobacco? ″ Yes ″ No

If yes, please explain: _____

- Are you currently pregnant? ″ Yes ″ No

To the best of my knowledge, all of the preceding answers are correct. I must notify the dentist and the staffs at the next appointment without fail if there are changes in my health status or if my prescription changes.

Date: _____

Patient's signature, parent or guardian:

X _____ Relation: _____

Dental Health Ouestionnaire

The cornerstone of our practice is the examination process. Our first task is to help you identify what it is that you want, both in the short term and in particular, for the long term. We feel everyone deserves to know the state of their dental health, what is moving them away from health, and the choices available to restore their oral health. If your first appointment is for cleaning or an emergency visit, your exam will likely be cursory and limited x-ray. If you are here for a comprehensive exam, we will examine your soft tissues, teeth gums, and chewing system. Depending on the clinical findings, we will take appropriate x-rays, impressions for models of your teeth, and photographs.

Excellence in dentistry begins with careful diagnosis and treatment plan. Once all your diagnostic records have been completed and evaluated, we will visit with you and review the findings, discuss your options, and together, create a personalized plan. It is important to note that once we have agreed on your plan, that quality is the constant and time is the variable. **You always control how far and at what pace we will proceed.**

Please help us better understand your dental health needs and goals by answering the following questions below (check the best answer):

1. **I have a fear of going to the dentist? ″ Y ″ N**
2. **My mouth and teeth are comfortable? ″ Y ″ N**
3. **I am satisfied with the appearance/condition of my teeth? ″ Y ″ N**
4. **I think my present state of dental health is? ″ Good ″ Fair ″ Bad**
5. **I would say my main concerns with my dental health are?**

6. **I'm interested in a smile evaluation and personalized treatment plan to enhance my smile. ″ Y ″ N**
7. **Have you had a FULL MOUTH set of X-rays (other than routine cavity detecting X-ray) within the last 3 years? ″ Y ″ N**
8. **In your own words, please describe what you feel are your main dental problems. Please describe the most important first:**

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9. **How and when did your problem(s) first begin?**

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10. **Have you received any injury such as a blow to any part of the body, concussion, whiplash, and any form of accident? If so when?**

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11. **Are you restricted in your work or unable to work?**

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12. **Have you had any assessments or consults? If so, with who and when?**

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13. **What treatment, if any, have you received by health professionals or others?**

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14. **What were your treatment results? Were they helpful or not?**

Screening for Sleep Apnea

ARE YOU FEELING RESTED?
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate situation:

Sitting and Reading *
- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

Watching TV *
- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

Sitting, inactive in a public place (ex: meeting) *
- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

As a passenger in a car for an hour without a break *
- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

Lying down to rest in the afternoon when circumstances permit *
- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

Sitting and talking to someone *
- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

In a car, while stopped for a few minutes in the traffic *
- 0 - Would never doze

″ 1 - Slight chance of dozing
″ 2 - Moderate chance of dozing
″ 3 - High chance of dozing

ARE YOU FEELING FATIGUED?
Please write the number between 1 and 7, which you feel best, fits the following statements. This refers to your usual way of life within the last week.

Scoring: 1 indicates “strongly disagree” and 7 indicates “strongly agree.”

____ My motivation is lower when I am fatigued

____ Exercise brings on my fatigue

____ I am easily fatigued

____ Fatigue Interferes with my physical functioning

____ Fatigue causes frequent problems for me

____ My fatigue prevents sustained physical functioning

____ Fatigue interferes with carrying out certain duties and responsibilities

____ Fatigue is among my three most disabling symptoms

____ Fatigue interferes with my work, family, or social life

ARE YOU AT RISK OF SLEEP APNEA?

Please answer the following questions by checking “yes” or “no” for each one:

Snoring (Do you snore loudly?)
″ Yes ″ No

Tiredness (Do you often feel tired, fatigued, or sleepy during the daytime?)
″ Yes ″ No

Observed Apnea (Has anyone observed that you stop breathing, or gasp during sleep?)
″ Yes ″ No

High Blood Pressure (Do you have or are you being treated for high blood pressure?)
″ Yes ″ No

BMI (Is your body mass index more than 35 kg per m^2?)
″ Yes ″ No

DO YOU HAVE TROUBLE BREATHING THROUGH YOUR NOSE?

Please help us to better understand the impact of nasal obstruction on your quality of life by completing the following survey. Over the past ONE month, how much of a problem were the following conditions for you?

- Nasal congestion or stuffiness
  - ☐ Not a problem
  - ☐ Very mild problem
  - ☐ Moderate problem
  - ☐ Fairly bad problem
  - ☐ Severe problem

- Nasal blockage or obstruction
  - ☐ Not a problem
  - ☐ Very mild problem
  - ☐ Moderate problem
  - ☐ Fairly bad problem
  - ☐ Severe problem

- Trouble breathing through my nose
  - ☐ Not a problem
  - ☐ Very mild problem
  - ☐ Moderate problem
  - ☐ Fairly bad problem
  - ☐ Severe problem

- Trouble sleeping
  - ☐ Not a problem
  - ☐ Very mild problem
  - ☐ Moderate problem
  - ☐ Fairly bad problem
  - ☐ Severe problem

APPOINTMENTS

Because we reorganize the value of your time, you can expect us to see you at the appointed time, so as to keep your time spent in our office as short as possible. Likewise, when you make n appointment with us we have reserved our time for you and ask that you be on time. **If you cannot keep your appointment we ask you to give us at least 48 hours' notice so that we can give your time slot to another patient. Otherwise, our office policy is to charge you an hourly rate to help defer some of the overhead expense associated with the loss of time.** We believe very strongly that mutual trust and respect for each other's time will strengthen our relationship.

FINANCIAL POLICY

Unless another financial option is pre-arranged, payment in full is due the day of treatment.

Payment Options

1. For your convenience we accept Cash, Check, Visa, Master Card, and Discover.
2. Feel free to discuss your financial concerns with any of our staff. We are committed to helping you remove all barriers on your journey to health.

For patients with Dental Insurance:
As a courtesy, we will assist you in getting your benefit from your insurance company.

AUTHORIZATION AND CONSENT

GENERAL CONSENT TO TREATMENT:

I agree and consent to a dental examination by Dr. Vann. I understand that additional diagnostic procedures and treatments may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the result of any procedures or dental treatment.

Release of Information

I authorize Dr. Vann to release any information regarding my dental/medical history, diagnosis or treatment on third party payers and/or other health professionals.

Photography Release

I authorize Dr. Vann to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize her to show these photographs in an educational setting as well as to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

My signature acknowledge that:
I understand the office policy with keeping appointments.
I understand and comply with the Office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
Photographs taken of me may be used in a teaching environment.
I have received a copy if the offices Notice of Privacy Practices.

Date: _____

Signature of patient, parent or guardian:

X _____ Relation: _____