HEALTHY SMILES
DENTAL CENTER

Cosmetic & Family Dentistry
3620 S Bristol St, Suite 103
Santa Ana, CA 92704
Tel: 714-432-0979
Fax: 714-432-1279

Patient Information

The following information is confidential & for our records only

Patient Information

Patient Name: _____
Last MI First

Date of Birth (month/day/year):_____ Social Security #:_____ Driver's License #:_____

Home Address:_____ City:_____ Zip:_____

Home Telephone: ( )_____ Cell Phone:_____ Email:_____

Emergency Contact Name:_____ Emergency Contact Telephone #: ( )_____ May we send you text messages? Y N

Employer Information

Employer Name: _____ Occupation: _____

Work Address: _____ City:_____ Zip: _____

May we contact you by email? Y N

Work Telephone #:( )_____ Ext:_____ Email:_____

DO NOT CONTACT ☐

Spouse's Information (Guardian if patient under 18)

Spouse's (Guardian) Name: _____ Date of Birth: _____

SSN: _____ Driver's License: _____

Home Address (if different from above): _____

City: _____ Zip:_____ Home Telephone #: ( ) _____

Employer Name: _____ Occupation: _____

Work Address: _____

City: _____ Zip: _____ Work Telephone #: ( )_____

Insurance Information

Insurance Company:_____ Insurance Company Phone #: ( )_____

Primary Holder Name:_____ Name of Plan: _____ Group:_____

How did you hear about our office? _____

Notice of Responsibility

I understand that I am personally responsible for the cost of my dental care, regardless of any insurance and will notify this office of any change in eligibility for insurance coverage. All the information above is true to the best of my knowledge. I understand that all x-rays are the property of Healthy Smiles Dental Center, however a digital copy of the x-rays may be obtained by request with a paid fee.

_____ _____

PATIENT SIGNATURE DATE

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HEALTHY SMILES
DENTAL CENTER

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____

Patient Address: _____

Patient Phone Number: _____

I authorize the professional office of my dentist named to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. A detailed description of the information to be released.
2. To whom may the information be released (name(s) or class(es) of recipients).
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).
4. An expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office listed at the top of this form.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re• disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. [For marketing authorizations, include, as applicable: We will receive direct or indirect renumeration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated:_____ Patient Signature:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient_____ Print Name_____

Source of Authority_____

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THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or healthcare operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other healthcare or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Healthcare operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense or legal matters; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigative or surveillance; and notices to and from federal food and drug administration regarding drugs or medical devices;
- Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by medicare or medicaid; or for investigative of possible violations of healthcare laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ and/or tissue donations;

- Uses or disclosures for health related research;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or healthcare operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform healthcare operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the uses or disclosures. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send it to the office named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information.
You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office at the address or fax number shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by sending an e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address or fax number shown at the beginning of this notice.
- Ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office at the address or fax number shown at the beginning of this notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. Ifwe do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request to the address or fax number shown at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or healthcare operations; disclosures with your healthcare authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it. By law, we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office at the address or fax number shown at the beginning of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you have one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address or fax number at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post iton our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us, the U.S. Department of Health and Human Services, or the Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, or fax number shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you need more information about our privacy practices, call or visit the office shown at the beginning of this notice.

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and received a copy (or will be maintained on file), of Healthy Smiles Dental Center Notice of Privacy Practices.

Patient name: _____

Signature:_____ Date: _____

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PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist:_____ Last Visit:_____ Date of last cleaning:_____

Reasons for changing dentist: _____

What problems have you had with dental treatment?_____

Are you nervous about seeing a dentist? ☐ Yes ☐ NO If yes, please tell us why:_____

How often do you brush?_____ Do You Floss? ☐ Yes ☐ No How often?_____

(Please circle Yes or No)

Y N I clench/grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontic work done.
Y N I have had a facial or jaw injury.
Y N I want to straighten my teeth.
Y N I want my teeth to be whiter.

What are your dental priorities?_____
(e. g.: dental health, financial considerations, etc.)

PATIENT'S MEDICAL HISTORY

I consider my health to be (please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? (Please circle Yes or No)

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ☐ Hip ☐ Knee ☐ Other:_____
16. Y N I smoke or use tobacco. If yes, how much per day?_____ How many years? ____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year:_____ Type of operation:_____
21. Y N Liver Disease
22. Y N Jaundice
23. Y N Hepatitis Type
24. Y N Diabetes
25. Y N Excessive Urination and or Thirst
26. Y N Infectious Mononucleosis (Mono)
27. Y N Herpes
28. Y N Arthritis
29. Y N Sexually Transmitted/Venereal Disease
30. Y N Kidney Disease
31. Y N Tumor or Malignancy
32. Y N Cancer? Chemotherapy
33. Y N Radiation Treatments
34. Y N History of Drug Addiction
35. Y N AIDS
36. Y N Immune Suppressed
37. Y N Disorder Hearing Loss
38. Y N Fainting
39. Y N Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you pregnant or nursing?

Are you allergic to any of the following:
(Please circle Yes or No)

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/ Sulfides
Y N Penicillin
Y N Codeine
Y N Latex,Metals, Plastics
Y N Local Anesthetics (Novocain)
Y N Other Medications - Which ones?

Please list all medications you are currently taking:

Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Medicine:_____ Condition:_____

Physicians Name _____ Phone_____
Address_____ Fax_____

Y N Do you snore?
Y N Do you use a CPAP machine?

In the event of an emergency please contact:

Name:_____ Relationship:_____ Phone:_____

Initial medical review by:

_____

Doctor's Signature Date Patient's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT CONSENT TO TREATMENT

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In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate. (Initials)_____

{ } 1. DRUGS, MEDICATIONS AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, or cardiac arrest.

I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four {24} hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/ or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate", Zanax, or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible serious side effects, such as obstruction of airway. (Initials)_____

{ } 2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

PERIODIONTICS - I understand that I have a serious condition, causing gum and bone inflammation and /or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand, that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. (Initials)_____

{ } 3. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
B. Injury to adjacent teeth, caps or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
C. Limitation of opening; stiffness of facial and /or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity above the upper teeth) requiring additional surgery.
G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth and/or tongue on the operated side, this may persist for several weeks, months, or in remote instances, permanently.

(Initials)_____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor 's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he/she may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initials)_____

{ } 4. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by your dentist. The advantages and disadvantages of alternate materials have been explained to me. (Initials)_____

{ } 5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth of facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instruments during treatment, which may, in the judgment of the doctor, be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not a permanent treatment, and will require paying for and finishing final root canal therapy. If root canal treatment is not finalized, I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted. (Initials)_____

(} 6. CROWN AND BRIDGES (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleaning, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials)_____

{ } 7. DENTURES - COMPLETE OR PARTIAL:

The problems of wearing dentures have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i e. tori/bone) removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction. (Initials)_____

{ } 8. PEDODONTICS (CHILD DENTISTRY):

I understand that the following procedures are routinely used at this dental office, as well as being accepted procedure in the dental profession: (Initials)_____

A. POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior by use of compliments, praise, a pat or a hug, and/or token objects or toys.
B. VOICE CONTROL – The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT–Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. NITROUS OXIDE and/or ORAL SEDATION – Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use, the parent/guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.
I understand the need to return to the office, for evaluation if swelling and/or pain in my child does not go away after a sufficient period of time.
I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation and the possibility of it then needing an extraction. (Initials)_____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND / OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS AND CONDITIONS STATED, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION

I UNDERSTAND THESE DENTAL SERVICES ARE PROVIDED WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

Signature:_____ Print Name:_____ Date:_____
(Patient or Legal Representative)

Doctor:_____ Witness:_____

Office Policy

Cancellations & Rescheduling

To help provide you and your fellow patients efficient care and to manage our procedure scheduling better, please give the office 48 hours prior notice for all appointments that need to be cancelled or rescheduled.

A $75.00 charge will apply on failed appointments if the office is not notified within the stated 48 hour time frame.

Office Charges

- Returned checks will be assessed a $25.00 processing fee.
- Patient balances greater than 30 days will be subject to a 1.5% finance charge.
- Charges may apply for various office requests including:
    - chart copying
    - physician letters
    - non-urgent phone consultations
    - mailings
    - x-ray requests

Patient Signature_____ Date _____

Print Name_____

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Tel: 714-432.0979

Sleep Disorder Questionnaire

Patient Name: _____ Height: _____

Email: _____ Weight: _____

Gender: M F DOB: _____

- **OVER 18 M1LLION AMERICANS SUFFER FROM SLEEP APNEA**
- **PEOPLE WITH SLEEP APNEA ARE 3 TIMES MORE LIKELY TO BE INVOLVED IN MOTOR VEHICLE ACCIDENTS**
- **90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED**

Do you snore?	Yes	No
Do you have high blood pressure?	Yes	No
Have you gained weight and find it difficult to lose?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking of legs while asleep?	Yes	No
Do you lack energy upon waking in the morning?	Yes	No
Do you have a headache upon waking in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you wake up during the night and are unable to fall back asleep?	Yes	No
Do you find it difficult to stay awake during the day?	Yes	No

*****If you have answered YES to any one of the above questions please consult with your doctor*****

Epworth Sleepiness Scale

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. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0 = Would never doze 1 = Slight chance of dozing

2 = Moderate chance of dozing 3 = High chance of dozing

Sitting & reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting & talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	_____

*****If your Epworth score is 10 or greater please consult with your doctor*****

Physician Name: _____

Phone: _____ Fax: _____