ADVANTAGE DENTAL WESTON

17130 Royal Palm Blvd, Suite 3, Weston, FL 33326
Ph.: 954.384.7505
Email: advantagedental1@gmail.com

Patient Name:		**Date of Birth:**	
Name of Legal guardian (If patient is a minor):			
Social Security #:			
Address:			
City:	**State:**	**Zip:**	
Cell Phone:	**Email:**		
Occupation: **Work Phone:**	**Employer:**		
Marital Status: Single ☐ Married ☐ Divorced ☐ **Name of Spouse:**		**Number of Children:**	
Height:	**Weight:**	**Age:**	**Referred By:**
Previous Dentist:		**Phone:**	
Address:			
Date of your last medical examination:			
Name of Dental Insurance:			
Nearest relative not living with you?		**Phone:**	

Concerning fee for service dentistry, are you aware that you are responsible for all fees at the time treatment is rendered, unless prior arrangements are made? ☐ Yes ☐ No

CONSENT FOR TRAETMENT

I hereby certify that I can read, speak, and understand the English language and hereby grant my permission to Dr. Yelena Prato and/or their associates and staff to administer to myself, my child, or my legal ward, such medications and procedures that they deem necessary, in their professional judgment, for my oral of dental health. Also, I grant my permission for them to administer local anesthetics and other medically indicated drugs or pharmaceuticals they deem necessary, to use such operative and technical procedures necessary to complete a diagnosis and/or recommended and accepted treatment has been approved. I also grant my permission to acquire and use all or any part of my records, photographs, videotapes or films which may be required for examination, diagnosis, treatment, instruction and/or scientific publication. For any purpose whatsoever, in any medium now known or in the future invented. I hereby release, discharge, and agree to hold harmless Advantage Dental Weston/Dr. Yelena Prato and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio or photographic production.

Patient Signature (or Legal Guardian)**:** ______________________________ **Date:** __________________

Patient Name (or Legal Guardian)**:** _________________________________

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MEDICAL HISTORY

Family Physician:	
Address:	**Phone:**
In case of Emergency, notify:	
Relationship:	**Phone:**

Please check "Y" for yes or "N" for no:

	Y N			Y N			Y N	
1.	☐☐	Medical Problem	14.	☐☐	Headaches	27.	☐☐	Major Operation
2.	☐☐	Heart Trouble	15.	☐☐	Anemia	28.	☐☐	Serious Accident
3.	☐☐	Heart Murmur	16.	☐☐	Fainting/Dizziness	29.	☐☐	HIV+
4.	☐☐	Rheumatic Fever	17.	☐☐	Strokes	30.	☐☐	Hepatitis
5.	☐☐	High Blood Pressure	18.	☐☐	Insomnia	31.	☐☐	Tumor/Cancer
6.	☐☐	Low Blood Pressure	19.	☐☐	Nervous Disorder	32.	☐☐	Arthritis
7.	☐☐	Pain in Chest	20.	☐☐	Psychiatric Treatment	33.	☐☐	Excessive Bleeding
8.	☐☐	Shortness of Breath	21.	☐☐	Diabetes	34.	☐☐	Kidney Problems
9.	☐☐	Asthma/Hay Fever	22.	☐☐	Ulcers	35.	☐☐	Liver Problems
10.	☐☐	Cough	23.	☐☐	Supervised Diet	36.	☐☐	Alcohol Dependency
11.	☐☐	Tuberculosis	24.	☐☐	Change in weight	37.	☐☐	Tobacco Dependency
12.	☐☐	Prosthetic Replacement	25.	☐☐	Easily Fatigued	38.	☐☐	Drug Dependency
13.	☐☐	Communicable Disease	26.	☐☐	Swollen Ankles	39.	☐☐	Medication Allergies

If yes, please explain (by number):

List all Medication (include aspirin, sleeping medication, sedative):	
Taking:	For:
Taking:	For:
Taking:	For:

Women:

1. ☐ Y ☐ N Pregnant? _________ Months?
2. ☐ Y ☐ N Miscarriage?
3. ☐ Y ☐ N Menopause/Supportive Medication?

Do you need to be pre-medicated?

☐ Y ☐ N Medication: ____________________________________ For: ____________________________________

Are there any medical concerns or lifestyle situations that you would like to discuss?

☐ Y ☐ N Explain: ____

Patient Signature (or Legal Guardian)**:** ______________________________________ **Date:** ________________________

Patient Name (or Legal Guardian)**:** ____

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NEW PATIENT DENTAL HISTORY

The following are intended to assist us in providing you with the most comprehensive and preventative dental care according to your present dental condition and your expectations of high quality personal dental care. Please answer each question by placing a check on "Y" for yes or "N" for no. Thank you.

1. When was your most recent prophylaxis? (teeth cleaning)
   Over 2 years ago ☐ Over 1 year ago ☐ within the last year ☐

2. Are you presently in any dental pain? ☐ Yes ☐ No

3. I am interested in a comprehensive dental examination to determine the present condition of my teeth and supporting tissues, the presence of any disease or infection and to determine what, if any, treatment I need. ☐ Yes ☐ No

4. I plan to have recommended dental treatment completed as soon as possible. ☐ Yes ☐ No

5. I am only interested in the "no charge" or "free" services as offered by my dental plan. ☐ Yes ☐ No

6. My teeth and their appearance could be improved. I am interested to learn about the latest developments in improving my smile and the appearance of my teeth. ☐ Yes ☐ No

7. Right now, my priorities and capabilities do include getting any teeth restored to their original, natural condition as soon as possible. ☐ Yes ☐ No

8. I plan to have my teeth repaired, restored or the missing ones replaced at the present time. ☐ Yes ☐ No

9. I would like to have any disease present in my mouth examined, diagnosed, identified and treated as soon as possible, even if I have to pay for such treatment out of my own pocket. ☐ Yes ☐ No

10. Have you ever had orthodontic treatment? ☐ Yes ☐ No

11. Do you have any growths or swellings in your mouth? ☐ Yes ☐ No

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NEW PATIENT DENTAL HISTORY (cont)

12. Do your gums bleed when brushing your mouth? ☐ Yes ☐ No
13. Have you ever had a bad reaction to a dental anesthetic? ☐ Yes ☐ No
14. Are you aware of stiff neck muscles? ☐ Yes ☐ No
15. Are you aware of clenching your teeth during daytime hours? ☐ Yes ☐ No
16. Have you ever been told you grind your teeth during sleep? ☐ Yes ☐ No
17. Are you aware of your jaw clicking or popping while eating or yawning? ☐ Yes ☐ No
18. Do you have difficulty in opening your mouth widely? ☐ Yes ☐ No
19. Do you have an unpleasant taste or odor in your mouth? ☐ Yes ☐ No

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Patient Name (or Legal Guardian)**:** _________________________________

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APPOINTMENT CANCELLATION POLICY

Dear Patient,

Please be advised that Advantage Dental Weston requires 24-hour notice to reschedule your appointment. If you fail to cancel your appointment within a 24-hour time, you will be billed a $50.00 fee.

Please contact out office immediately if you should have to cancel or reschedule your appointment.

Please sign below to indicate that you have read and understood this policy.

Patient Signature (or Legal Guardian)**:** ________________________________ **Date:** ____________________

Patient Name (or Legal Guardian)**:** ___________________________________

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RESPONSIBILITIES AND PAYMENT OPTIONS

We are committed to providing the best dental care possible. If you have dental insurance, we will gladly help you understand and maximize your allowable benefits. In case you don't have dental insurance, payment for services is due at the time services are rendered. We accept cash, checks, credit cards, and debit cards. We can also offer financing options through Care Credit.

Please be informed there is a $25.00 charge for all returned checks. Balances older than 30 days will be subject to additional charges.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contact.
2. You are responsible for your deductible and any portion your insurance does not pay. "Usual, Customary and Reasonable" charges are determined by each individual insurance company. "UCR is determined by both geographical region and the contract between your employer and the insurance company.
3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover.
4. Balances, which have not been paid within 90 days, will be sent over to a collection agency. Should this account become a collection matter, the patient or legal guardian assumes all cost of collection, including, but not limited to the court costs, interest and legal fees.

If you have questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help.

I have truly read and understand that I am responsible for all cost of Dental Treatment.

Patient Signature (or Legal Guardian)**:** ________________________________ **Date:** ____________________

Patient Name (or Legal Guardian)**:** ___________________________________

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HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

I acknowledge that I have been provided with **YELENA PRATO-GUIA DMD, INC.,** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and/or permitted by law.

Patient Signature (or Legal Guardian)**:** ________________________________ **Date:** ___________________

Patient Name (or Legal Guardian)**:** ___________________________________

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **YELENA PRATO-GUIA DMD, INC., (YPG)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **YPG** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **YPG** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **YPG** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

PATIENT ACKNOWLEDGMENT & AGREEMENT

My Consented Email Address is:____

My Consented Mobile Number for Text Messaging is:____

Patient Signature (or Legal Guardian)**:** ________________________________ **Date:** ____________________

Patient Name (or Legal Guardian)**:** ___________________________________

IN CASE OF EMERGENCY: please call 911 or proceed to the nearest emergency room. **Do not use this way of communication for that purpose**

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EPWORTH SLEEPINESS SCALE

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting an reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (at the movies)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

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STOP-BANG SLEEP APNEA QUESTIONNAIRE

Chung F et al Anesthesiology 2008 and BJA 2012

As part of our commitment to your overall health and well-being, we kindly ask you to complete the STOP-BANG Sleep Apnea Questionnaire. This questionnaire helps us assess your risk factors for sleep apnea, a condition that can impact both your dental health and general wellness.

STOP

Question		
Do you **S**NORE loudly (louder that talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG

Question		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40 cm)	Yes	No
GENDER: Male?	Yes	No

Patient Signature (or Legal Guardian)**:** ________________________________ **Date:** ____________________

Patient Name (or Legal Guardian)**:** ___________________________________