



COMPREHENSIVE DENTAL CENTER

Jack T. Winchester, DMD  Trust Experience.

3705 Symi Circle, Morehead City, NC 28557 (252) 247-3510 Fax: (252) 247-6197 www.MoreheadCityDental.com

We are committed to excellence in dentistry and 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 - we will be happy to help.

Tell us, how did you hear about us? _____

Mr. Ms. Miss Mrs. Dr.

ABOUT YOU

Name: _____ I prefer to be called _____ [] Male [] Female
[] Single [] Married [] Child [] Other Birth date: ___/___/___ Age: ___ S.S. #: _____
Home Address: _____ City _____ State _____ Zip _____
Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____
Cell: (____) _____ E-mail Address: _____
Employer: _____ How long there? _____ Occupation: _____
Employer's Address: _____ City _____ State _____ Zip _____
Emergency Contact Person: (Name) _____ (Phone) _____ (Relationship) _____

PERSON RESPONSIBLE FOR ACCOUNT

[] Same as above Name: _____ Birth date: ___/___/___ Relation: _____
Billing Address: _____ City _____ State _____ Zip _____
Home Phone: (____) _____ Work: (____) _____ S.S. #: _____
Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

[] Same as above Name: _____ Birth date: ___/___/___
Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I understand the insured party and/or guardian signing is financially responsible for any balances due, regardless of what my insurance pays, or does not pay. I also understand that if my insurance company does not pay within 120 days of my date of service then the insured party and/or guardian signing will become responsible to pay at that time.

I authorize that my records can be used by the doctor if he so determines to the making of videotapes, photographs, and x-rays before, during or after treatment, and to use of the same by the doctor in scientific papers or demonstrations for educational purposes.

I also have signed Consent of Dr. Winchester's Notice of Privacy Practices. (A full copy may be obtained by the office upon request). This allows Dr. Winchester's office to use my personal information from office to office, to an insurance company, for payment or to acquire records concerning your treatment both past and present.

I acknowledge that payment is due at the time services are rendered in full, minus insurance estimates, if benefits are available. If Insurance cannot be verified, you will be asked for payment in full. I understand that any credit of \$50.00 or less will not be issued unless used for procedures or I leave the office. I understand that refund checks will not be issued until all insurance payments have been received from my insurance company.

My form of expected payment will be made by:

CASH, CHECK, VISA, MASTERCARD, WELLS FARGO FINANCING, CARECREDIT

Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulpham | | | 32. neurologic problems (attention deficit disorder) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. venereal disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / drug dependency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. emphysema, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. digestive disorders (i.e. gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

ARE YOU:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. aware of a change in your general health _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. subject to frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. a smoker or smoked previously _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



**COMPREHENSIVE
DENTAL CENTER**

Jack T. Winchester, DMD  Trust Experience.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS REGARDING PATIENT INFORMATION

I request that the Comprehensive Dental Center communicate with me confidentially about dental matters in the following manner:

(It is the office policy of Comprehensive Dental Center – Jack T. Winchester, DMD and staff to not release confidential and/or unauthorized dental or medical or account information by home telephone, answering machine, work telephone, email address, voice mail, cell phone and/ or pager. Whenever returning phone calls and answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the residents. Information will also not be left with an unauthorized person who may answer the telephone.)

I authorize this Dental Provider and/or staff to leave dental or account information pertaining to my care by the following methods and will assume responsibility to notify whenever this information changes:

Home Telephone: Yes No Work Telephone: Yes No

Answering Machine Yes No Work Voice Mail Yes No

Cell Phone/Voice Mail Yes No

E-Mail Yes No E-Mail Address: _____

If you would like to have information released to someone other than yourself, please complete the following:

Spouse/Parent/Step Parent _____

Other Names (please list relationship such as relative, friend, siblings, caretaker, co-worker)

RIGHTS OF THE PATIENT

I understand I have the right to revoke this authorization and that I have the right to inspect or copy the protected health information to be disclosed in this document or by sending a written notice to Comprehensive Dental Center. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. For email communications, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

I understand that I have the right to refuse to sign this authorization and that any treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative, by signing in the authorization. This may not be a verbal notification, but must be done in written

Patient Printer Name

Patient/Patient Representative Signature

Date

If Patient Representative, Relationship to Patient

Doctor: _____
 Child's Name _____ Age _____ Date: _____
 Filled Out By: _____ Relationship to Patient: _____

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present 1 – 2 Mild 3 Moderate 4 - 5 Pronounced

Does your child:

	INITIAL	FOLLOW UP			INITIAL	FOLLOW UP	
1.	_____	_____	Snore at all?	14.	_____	_____	Talks in sleep
2.	_____	_____	Snore only infrequently (1 night/week)	15.	_____	_____	Poor ability in school
3.	_____	_____	Snore fairly often (2-4 nights/week)	16.	_____	_____	Falls asleep watching TV
4.	_____	_____	Snore habitually (5-7 nights/week)	17.	_____	_____	Wakes up at night
5.	_____	_____	Have labored, difficult, loud breathing at night	18.	_____	_____	Attention deficit
6.	_____	_____	Have interrupted snoring where breathing stops for 4 or more seconds	19.	_____	_____	Restless sleep
7.	_____	_____	Have stoppage of breathing more than 2 times in an hour	20.	_____	_____	Grinds teeth
8.	_____	_____	Hyperactive	21.	_____	_____	Frequent throat infections
9.	_____	_____	Mouth breathes during day	22.	_____	_____	Feels sleepy and/or irritable during the day
10.	_____	_____	Mouth breathes while sleeping	23.	_____	_____	Have a hard time listening and often interrupts
11.	_____	_____	Frequent headaches in morning	24.	_____	_____	Fidgets with hands or does not sit quietly
12.	_____	_____	Allergic symptoms	25.	_____	_____	Ever wets the bed
13.	_____	_____	Excessive sweating while asleep	26.	_____	_____	Bluish color at night or during the day
				27.	_____	_____	Speech Problems *

*If yes, provide parent speech questionnaire

Was your reason for coming to this doctor for sleep or dental issues: _____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #27 was indicated above

Please check all that apply to your child:

- | | |
|---|---|
| 1. _____ Is it difficult to understand your child's speech
2. _____ Difficult to understand over the phone?
3. _____ Nasal speech?
4. _____ Speech sounds abnormal?
5. _____ Others have difficulty understanding speech? | 6. _____ Gets frustrated when people can't understand speech?
7. _____ Sometimes omits consonants
8. _____ Uses M, N, NG instead of P, F, V, S, Z sounds
9. _____ Hoarseness
10. _____ Lisp
11. _____ Any speech therapy?
How Long? _____ |
|---|---|