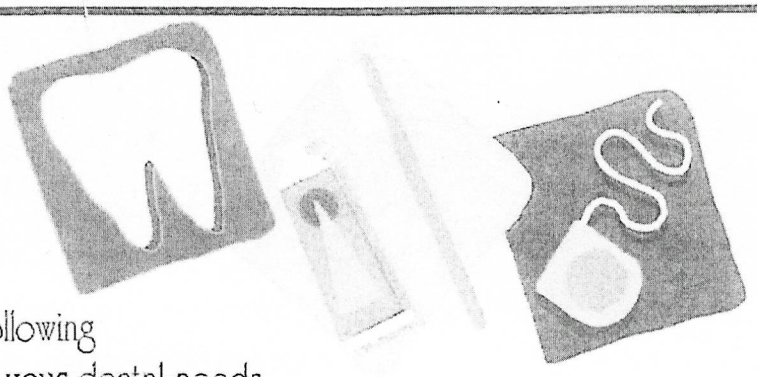
WELCOME
TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: _____

4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

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Financial Policy

If you have dental insurance coverage, we will be happy to assist you in using your benefit program. As a courtesy, we contact your insurance company to find out the percentages they pay on all services. If your insurance company figures payment from their own fee schedule, there may be an additional balance to you. Our office understands your insurance coverage and will help you maximize the benefits allowed under your plan. It is the patient's responsibility to keep track of the amount used of their yearly insurance maximum, exclusions, and waiting periods. This office will not be held responsible. Please notify us if you have used any of your insurance at another office during your current benefit year or if there have been any recent changes in the insurance coverage.

If you use your insurance benefits at this office you must realize that:

Your dental benefits are under a contract between YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. We are NOT a party to that contract.
Our fees generally are NOT fully covered by the maximum allowance determined by your carrier.
All dental services are NOT covered by benefits.
YOU are responsible for all fees incurred for services rendered to you.
Our treatment plans show **estimated** coverage.

Please discuss your proposed dental treatment with us and ask all necessary questions before you begin treatment.

Patient co-pays are due on the day services are rendered unless a plan has been pre-arranged.

Types of Payment we accept: Visa, MasterCard, American Express, debit Card, Care Credit and Cash Payments.

Patients of record there will be a $30 charge for returned checks.

Please give 48 hours of notice if you need to change your dental appointment.
There will be a minimum charge of $50.00 for last minute cancelations and no-shows.

I understand the above office policies:

Patient Signature: _____ Date: _____

Please Print Name: _____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Leena M Bahu, DDS, P.C & Associates

PLEASE SIGN THE FORM BELOW UNDER THE HEADING CONSENT FOR CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

Part 1: Acknowledgment of Receipt of Privacy Notices

I, _____, acknowledge that I have received a

Notice of Privacy Practices from the above named practice.

Signature:_____ Date: _____

If a personal representative signs this authorization on behalf of the individual please complete the following.

Personal Representative's Name:_____

Relationship to Individual: _____

PATIENT CONSENT

I consent to having the necessary, study models (impressions) and photographs needed for diagnostic and dental chart completion purposes. This information is not to be disclosed without the signed consent of the patient.

I attest that the above information is correct.
Print Name: _____

Patient Signature: _____ Date: _____

Part 2: Good faith effort to obtain acknowledgement of Receipt

Patient refused to sign:

Describe your good faith effort to obtain the individual's signature on the form:

_____

_____

Describe the reason why the individual would not sign the form.

_____

_____

Elite Dental Care
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MALLORY A. PAYNE, DDS
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Informed consent- General Dentistry

Examinations and x-rays and prophylaxis (cleaning)
I understand that the initial visit may require radiographs in order to complete the examination, and diagnosis. I understand treatment is preventive in nature, intended for the patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal(gum) disease. If periodontal disease is diagnosed, treatment will be discussed prior.

Drugs, Medication, and Nitrous Oxide
I have been informed and understand that antibiotics and analgesic and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the general anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical I tell my dentist of all medications I am currently taking. If I elect to have nitrous oxide in conjunction with my dental treatment, I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness, and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

Fillings
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function which may include root canal, crown, or both. Care must be exercised in chewing on fillings in the first 24 hours to avoid breakage. I understand that sensitivity is common with a newly placed filling.

Dental benefits and changes in treatment
I understand that my insurance may provide only the minimum standard of care and I may be responsible for additional costs that my insurance may not cover. I elect to follow the dentist's recommendation of optimal dental treatment. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. ***I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist or corporate entity, other than treating dentists, is responsible for my dental treatment.***

Signature:_____ Date:_____

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Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancer causes. * Oral cancer risk by patient profile as follows:

Increased risk:	patients ages 18-39 -sexually active patients (HPV)
High risk:	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
Highest risk:	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated Velscope powered by Sapphire into our oral screening standard of care. We find that using Velscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify sus picious areas at their earliest stages. VELscope Powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. Velscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest pos sible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Velscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is _____$40.00_____.

O Yes. I would prefer to have the Velscope powered by Sapphire exam at this time.

O No. I would prefer not to have the Velscope powered by Sapphire exam at this time.

Print Name _____
Signature _____Date_____

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Patient Name (PRINT) _____

Section 1 : Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0 = never, 1 = slight, 2 = moderate, 3 = high chance of dozing)–CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
Driving a car stopped for a few minutes in traffic	0	1	2	3
Sitting & talking to someone	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Total Score:_____

Section 2 : Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

	No (0)	Yes (1)
BMI (See Bottom Chart): _____ is it greater than or equal to 30?	0	1
Neck Circumference _____ _____ is it > 17" (Men) or >15" (Women)	0	1
Have you gained at least 15 pounds in the last 6 months?	0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please Circle one yes or no response for each question	No (0)	Yes (1)
Do you snore?	0	1
You, or your spouse, would consider your snoring louder than a person talking	0	1
Your snoring occurs almost every night	0	1
Your snoring is bothersome to your bed partner	0	1
Do you feel that in some way your sleep is not refreshing or restful?	0	1
Do you wake up at night or in the mornings with headaches?	0	1
Do you experience fatigue during the day and have difficulty staying awake?	0	1
Do you have trouble remembering things or paying attention during the day?	0	1
Do you have high blood pressure?	0	1

Total Score:_____

Patient Signature:_____ Date: ____/____/_____

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.
_____ESS Score ≥ 8? _____Pt. Eval≥2? _____Subjective sleep eval≥ 3? _____Prior OSA Diagnosis≥1?

$$BMI = \frac{703 \times \text{Weight (lb)}}{(\text{Height in inches})^2}$$

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SMILE EVLUATION

PATIENT NAME: _____ DATE: _____

(Circle One)

Are you pleased and confident with the way your teeth look when you smile? YES NO

Do you have some unwanted spaces or gaps between your teeth?_____ YES NO

Is there a chip or crack that you would like to have repaired?_____ YES NO

Are you concerned about one or perhaps more than one tooth that is discolored?_____ YES NO

Maybe you have some unattractive discolored metal or plastic fillings?_____ YES NO
(These can be an anterior "front" or posterior "back" teeth.)

Do you have teeth that are slightly out of line, overlapping or protruding?____ YES NO

How are your gums?

A. Are they red or swollen?_____ YES NO

B. Have they receded or shrunk from the top of your teeth?_____ YES NO

Do you have some missing teeth that should be replaced?_____ YES NO

Could your smile be improved if your teeth were:

☐ Whiter ☐ Longer ☐ Shorter ☐ Wider ☐ Narrower

Would you be interested in an Orthodontic Consultation with one of Dr. Leena Bahu's colleagues for yourself or your children? _____

Would you be interested in a cosmetic evaluation with Dr. Leena Bahu for Veneers, Implants, Crowns, and/or Whitening? .

The answers to these questions will help you and Dr. Bahu decide if cosmetic/restorative dentistry may improve your smile. The conservative nature of bonded/ porcelain restorations and their esthetic quality gives you something to smile about!

Reviewed:_____ Date:_____