

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ()		Business/Cell Phone: <i>Include area code</i> ()				
Address: _____ <i>Mailing address</i>			City: _____		State: _____ Zip: _____				
Occupation: _____			Height: _____		Weight: _____				
			Date of Birth: _____		Sex: M F				
SS# or Patient ID: _____		Emergency Contact: _____		Relationship: _____		Home Phone: <i>Include area code</i> ()			
						Cell Phone: <i>Include area code</i> ()			
If you are completing this form for another person, what is your relationship to that person?									
<i>Your Name</i>				<i>Relationship</i>					
Do you have any of the following diseases or problems:				<i>(Check DK if you Don't Know the answer to the question)</i>				Yes No DK	
Active Tuberculosis.....								□ □ □	
Persistent cough greater than a 3 week duration.....								□ □ □	
Cough that produces blood.....								□ □ □	
Been exposed to anyone with tuberculosis.....								□ □ □	
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.									

Dental Information *Please mark (X) your responses to the following questions.*

Yes No DK			Yes No DK		
Do your gums bleed when you brush or floss?..... □ □ □			Do you have earaches or neck pains?..... □ □ □		
Are your teeth sensitive to cold, hot, sweets or pressure?..... □ □ □			Do you have any clicking, popping or discomfort in the jaw?..... □ □ □		
Is your mouth dry?..... □ □ □			Do you brux or grind your teeth?..... □ □ □		
Have you had any periodontal (gum) treatments?..... □ □ □			Do you have sores or ulcers in your mouth?..... □ □ □		
Have you ever had orthodontic (braces) treatment?..... □ □ □			Do you wear dentures or partials?..... □ □ □		
Have you had any problems associated with previous dental treatment?..... □ □ □			Do you participate in active recreational activities?..... □ □ □		
Is your home water supply fluoridated?..... □ □ □			Have you ever had a serious injury to your head or mouth?..... □ □ □		
Do you drink bottled or filtered water?..... □ □ □			Date of your last dental exam:		
If yes, how often? <i>(Check one):</i> DAILY □ / WEEKLY □ / OCCASIONALLY □			What was done at that time?		
Are you currently experiencing dental pain or discomfort?..... □ □ □			Date of last dental x-rays:		
What is the reason for your dental visit today?					
How do you feel about your smile?					

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK			Yes No DK		
Are you now under the care of a physician?..... □ □ □			Have you had a serious illness, operation or been hospitalized in the past 5 years?..... □ □ □		
Physician Name: _____			If yes, what was the illness or problem?		
Phone: <i>Include area code</i> ()					
Address/City/State/Zip:			Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... □ □ □		
			If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:		
Are you in good health?..... □ □ □			_____		
Has there been any change in your general health within the past year?..... □ □ □			_____		
If yes, what condition is being treated?			_____		

Date of last physical exam:			_____		

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;">Yes No DK</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? <i>Circle one: VERY / SOMEWHAT / NOT INTERESTED</i></p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cocaine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p style="text-align: right;">Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: *Include area code*
()

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

SMART SMILE DENTAL

Dr. Lori Bagai DDS Inc

FINANCIAL OPTIONS

Our commitment is to provide quality comprehensive dental care to the entire family through exceptional service and utilization of advanced technology.

METHODS OF PAYMENT

Cash, check or credit card, Dental Insurance, CareCredit

DENTAL INSURANCE

1. We are pleased that you have dental insurance and our office will assist you in obtaining the maximum benefit specified in your contract. **Your insurance is between you, your employer and the insurance company.** You are responsible for all payments due.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization. We will wait 30 days for insurance payment, after 30 days you are responsible for the payment that is expected from the insurance. Once we have received the Explanation of Benefit from the insurance, adjustments will be made and your account reconciled.
3. **We ask that your estimated co-payment and deductible be paid at the time of scheduling the appointment.**
4. Some insurance companies deny coverage because in their opinion the treatment was not needed. We use our clinical judgement and training in diagnosing according to standard of care. **If services are rendered and insurance denies payment for any reason, payment is due in full as soon as the claim processes.**

RELATED INFORMATION

1. In the event that the account is not paid and we refer the account to collection, you will be responsible for all of the fees incurred in the collection of your bill (i.e. attorney fees, court costs and collection agency fees).
2. Your appointment time and chair has been reserved exclusively for you. Any change in your appointment affects many patients, 48 hours advanced notice is needed to avoid a \$75 charge. If you have a 2 hour or longer appointment, the fee will be \$150.
CANCELLATIONS: To avoid a cancellation fee you must cancel the appointment 48 hours in advance. 48 hours is defined as two business days. Messages left over the weekend are not considered sufficient notice. *NO Email/Text/Online CANCELLATIONS*
3. Promotional treatment costs are final and refunds are not permitted.

Who may we thank for referring you?

- Online Word Search _____
- Insurance _____
- Friend/Patient _____

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from the services rendered. I agree to be responsible for any charges not paid by my dental plan.

Patient's NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS;
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to **Dr. Lori Bagai / Smart Smile Dental**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____

Patient Full Name (printed): _____

Parent Signature (if minor): _____

Witness: _____

Date Signed: _____

Patient Name: _____

Patient DOB: _____

Date: _____

Epworth Sleepiness Scale Questionnaire

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

1. Have you ever been told you stop breathing while asleep?	Y / N	8
2. Have you ever fallen asleep or nodded off while driving?	Y / N	6
3. Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y / N	6
4. Do you feel excessively sleepy during the day?	Y / N	4
5. Do you snore, or have you ever been told that you snore?	Y / N	4
6. Do you have trouble falling asleep?	Y / N	4
7. Do you have trouble staying asleep once you fall asleep?	Y / N	4
8. Do you kick or jerk your legs while asleep?	Y / N	3
9. Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y / N	3
10. Do you wake up with headaches during the night or in the morning?	Y / N	3
11. Have you had weight gain and found it difficult to lose?	Y / N	2
12. Have you taken medication for, or been diagnosed with high blood pressure?	Y / N	2
Total Score		

For Doctor/Staff Use Only

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications:

- Enlarged/Scalloped Tongue
- Retruded Lower Jaw
- High Arching Hard Palate
- Bruxism
- Gastroesophageal Reflux
- Enlarged Tonsils
- Mouth Breather

Have you ever been diagnosed with a sleep disorder? Yes or No

Are you currently using a CPAP machine? Yes or No (if yes) Do you use it every night? Yes or No

Notes:

**COMPARISONS OF DIRECT/INDIRECT RESTORATIVE
DENTAL MATERIALS ACKNOWLEDGEMENT
AND HIPAA ACKNOWLEDGEMENT**

**COMPARISONS OF DIRECT/INDIRECT RESTORATIVE
DENTAL MATERIALS ACKNOWLEDGEMENT**

I have received the Notice of Comparisons of Direct/Indirect Restorative Dental Materials, and I have been provided an opportunity to review them.

Name: _____ Birthdate: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

SIGN BELOW THAT YOU HAVE RECEIVED THIS INFORMATION.

Name: _____

Signature: _____ Date: _____



Dr. Lori Bagai, DDS
1110 E Chapman Ave, Suite 105, Orange, CA 92866
Email: staff@smartsmileoc.com
Tel: (714) 744-1242
smartsmileoc.com

Name: _____

What issue(s) or area(s) about your oral health and smile would you like to address?

How urgent are these for you on a scale of 1-10, with 10 being the most urgent?

Your oral health is important to us, and we want to ensure you have a plan for obtaining optimum oral wellness. What is your financial plan for this treatment? Would you like information regarding financing options you may qualify for?

When it comes to your medical and financial decisions, is there anyone else that will need to be included in the overall discussion of your treatment plan and cost before moving forward with your treatment? If so, please let us know so we can make special accommodations for you.

PHARMACY LOCATION

Patient Name: _____ Date: _____

Pharmacy Name: _____

Phone Number: _____

Street Address: _____

City: _____

Zip Code: _____

Cross Street: _____