

**WE WOULD LIKE TO GET TO KNOW YOU**

Today's Date: \_\_\_\_\_ Sex F M Date of Birth: \_\_\_\_\_  
 Mr. Mrs. Ms. Dr. \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Marital Status: M S W D Number of children: \_\_\_\_\_ Children's ages: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Preferred communication: Phone call Email Text Message  
 Are you presently employed? Yes No Full-Time Part-Time Unemployed Disabled Retired  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
 What is the reason for seeing us today? \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_  
 What can we do to ensure your experience with us is a pleasant one? \_\_\_\_\_  
 What was the reason you stopped seeing your previous dentist? \_\_\_\_\_

**INSURANCE INFORMATION**

Will we be billing dental insurance for you? Yes No  
 Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_  
 Subscriber ID or SS#: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

**MEDICAL HISTORY**

Last physical exam \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
 Name of physician: \_\_\_\_\_ Phone number of physician: \_\_\_\_\_

**Please check if you have ever had any of the following:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Allergies / Hay Fever  | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Allergies / other      | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> HIV positive / AIDS   | <input type="checkbox"/> Severe headaches     |
| <input type="checkbox"/> Allergy / Aspirin      | <input type="checkbox"/> Depression                | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Allergy / Codeine      | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Sleep Apnea          |
| <input type="checkbox"/> Allergy / Erythromycin | <input type="checkbox"/> Earaches, ringing in ears | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> STD                  |
| <input type="checkbox"/> Allergy / Latex        | <input type="checkbox"/> Eating Disorder           | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Stomach / intestinal |
| <input type="checkbox"/> Allergy / Penicillin   | <input type="checkbox"/> Epilepsy / Seizures       | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Allergy / Sulfa        | <input type="checkbox"/> Fainting / Dizzy spells   | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Systemic Lupus       |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Heart attack              | <input type="checkbox"/> Prosthetic joint      | <input type="checkbox"/> Tumors               |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart disease             | <input type="checkbox"/> Panic Attacks         | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart murmur              | <input type="checkbox"/> Radiation Therapy     |   |
| <input type="checkbox"/> Breast Implants        | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Respiratory Problems  |   |

**If you checked any of the above questions or have any other medical conditions, please explain:**

Major illnesses /operations? \_\_\_\_\_ Allergies to medications \_\_\_\_\_

Are you allergic to latex? Yes No Number of alcoholic drinks per week \_\_\_\_\_

Do you or have you ever smoked or used chewing tobacco? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Have you ever taken "bisphosphonates" (Fosamax, Actonel, Aredia, or Pamidronate?) Yes No

Do you need to be pre-medicated with antibiotics for dental treatment? Yes No

Women only:

Any chance you are pregnant \_\_\_\_\_ Are you nursing? \_\_\_\_\_ Are you taking birth control pills? \_\_\_\_\_

Please list any medications that you are currently taking: \_\_\_\_\_

### DENTAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_ Date of last dental exam \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

**Please check all that apply to you:**

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Bleeding gums        | <input type="checkbox"/> Tooth removal   | <input type="checkbox"/> Food gets stuck   | <input type="checkbox"/> Accident in past      | <input type="checkbox"/> Pain when chewing |
| <input type="checkbox"/> Tooth decay          | <input type="checkbox"/> Braces          | <input type="checkbox"/> Loose teeth       | <input type="checkbox"/> Gum surgery           | <input type="checkbox"/> Jaw surgery       |
| <input type="checkbox"/> Broken teeth         | <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Toothache         | <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Loose teeth       |
| <input type="checkbox"/> Hot / cold sensitive | <input type="checkbox"/> Wear of teeth   | <input type="checkbox"/> Crowding of teeth | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Dry mouth         |

**Are you happy with the way your teeth look?** \_\_\_\_\_ If not, why not? \_\_\_\_\_

**Are you dissatisfied with any of the following?**

- |   |  |  |  |                                     |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> Shape of teeth | <input type="checkbox"/> Crowding                | <input type="checkbox"/> Visible silver fillings | <input type="checkbox"/> Color         | <input type="checkbox"/> Length     |
| <input type="checkbox"/> Spaces         | <input type="checkbox"/> Old discolored fillings | <input type="checkbox"/> Misalignment            | <input type="checkbox"/> "Gummy" smile | <input type="checkbox"/> Old crowns |
| <input type="checkbox"/> Bad bite       | <input type="checkbox"/> Other _____             |  |  |                                     |

**Do you have any sores / spots in mouth that haven't healed for more than 2 weeks?**  Yes  No

### TMJ EVALUATION

**Please check all that apply to you:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> TMJ problems        | <input type="checkbox"/> Ringing in ears ("tinnitus") | <input type="checkbox"/> Difficulty opening mouth        | <input type="checkbox"/> Difficulty chewing   |
| <input type="checkbox"/> Clicking in jaw     | <input type="checkbox"/> Numbness in face / jaw       | <input type="checkbox"/> Decreased ability to open mouth | <input type="checkbox"/> Dizziness (vertigo)  |
| <input type="checkbox"/> Pain in jaw         | <input type="checkbox"/> Neck or back pain            | <input type="checkbox"/> Numbness / tingling in fingers  | <input type="checkbox"/> Pain behind eyes     |
| <input type="checkbox"/> Grinding teeth      | <input type="checkbox"/> Jaw clenching                | <input type="checkbox"/> Wear a nightguard               | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> Pain in facial area | <input type="checkbox"/> Tightness around face        | <input type="checkbox"/> History of jaw lock             | <input type="checkbox"/> Bells Palsy          |

### HEADACHE HISTORY

Location of pain:  Front of head / forehead  Sides of head  Back of head

Intensity of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Do you suffer from morning headaches?  Yes  No  Sometimes

Do headaches wake you up from sleep?  Yes  No  Sometimes

Do you have any nausea with headaches?  Yes  No  Sometimes

Frequency of headaches:  constant  once a day  once every few days  once a week

### SLEEP ASSESSMENT

**Have you ever been diagnosed with Sleep Apnea?**  Yes  No If yes, when? \_\_\_\_\_

Diagnosing physician: \_\_\_\_\_ Name of Sleep Center \_\_\_\_\_

**Please check all that apply to you:**

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Snoring      | <input type="checkbox"/> Gastro-esophageal reflux  | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Gasping for air during the night  |
| <input type="checkbox"/> Poor memory  | <input type="checkbox"/> Feel tired in the morning | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Difficulty breathing through nose |
| <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Trouble sleeping          | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Excessive daytime sleepiness      |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Anxiety / depression      | <input type="checkbox"/> Morning stiffness  |  |

**What is the chance that you will dose off in the following situations?**

Sitting and reading:  
 No chance  Slight chance  Moderate chance  High chance

Watching TV:  
 No chance  Slight chance  Moderate chance  High chance

Sitting in active in a public place (theater or meeting):  
 No chance  Slight chance  Moderate chance  High chance

As a passenger in a car for an hour without a break:  
 No chance  Slight chance  Moderate chance  High chance

Lying down to rest in the afternoon when circumstances permit:  
 No chance  Slight chance  Moderate chance  High chance

Sitting and talking to someone:  
 No chance  Slight chance  Moderate chance  High chance

Sitting quietly after a lunch without alcohol:  
 No chance  Slight chance  Moderate chance  High chance

In a car, while stopped for a few minutes in traffic:  
 No chance  Slight chance  Moderate chance  High chance

**If you have ever used a CPAP device and could not tolerate it, please give the reasons why:** \_\_\_\_\_

# Insurance Policy

Helping you maintain great oral health is our biggest priority. The benefits of a happy, healthy smile are immeasurable, and it is our goal to work with you to reach and maintain maximum oral and overall health.

In order to provide you with the best care available, there are some guidelines that have been established. Please read the information below, and we would be happy to discuss any of the policies with you.

## DENTAL INSURANCE

**\_\_\_\_\_** We are providers for most dental insurance plans, and always abide by the terms of our contract with your insurance company. Our fees are those set by your insurance company, and your co-pays and / or deductibles are dictated by your plan. Therefore, **any co-pays or deductibles are due in full at the time of treatment.**

**\_\_\_\_\_** Before treatment is started, you will receive a treatment plan, detailing any co-pays / deductibles that you will be responsible for. **The treatment plan is only an estimate, and can change based on our findings during treatment.**

**\_\_\_\_\_** You will receive an explanation of benefits (EOB) from your insurance company a few weeks after the information about your treatment has been submitted to your dental insurance. **If you have concerns about your treatment plan or the EOB, please feel free to contact us any time, and we will be happy to answer any questions that you have.**

**\_\_\_\_\_** Certain procedures may not be covered by your insurance plan, or may have a frequency limitation. In that case, **you will be fully responsible for payment for those services in full at the time of treatment.**

## MEDICAL INSURANCE

**\_\_\_\_\_** As a courtesy, we will file your claim with your medical insurance and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow. We are only able to give an estimation of costs toward your treatment and you are responsible for any costs not covered by your medical insurance.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payments on my account.

I understand that all treatment plans are ESTIMATES and that I may receive a statement for services not covered after my insurance has paid.

**I have read the above policies and agree to abide by them.**

---

Signature of Patient/Guardian

Date

## Agreement and Consent

1. I authorize and give consent to the doctor and the staff to administer treatment, including, but not limited to local anesthesia, analgesia, x-rays, photographs and any other treatment that in their judgment, may be necessary for dental health. I understand the use of medications, anesthetics and some procedures may embody a certain amount of risk. This may include allergic reactions and/or other reactions/sensitivities. If I am female using oral contraceptives, I understand that antibiotics or other medications may interfere with the effectiveness of oral contraceptives. It is my responsibility to inform the doctor of any medical or dental conditions or concerns I may have.
2. I understand and agree that all photographs are the sole property of Olya Banchik DDS.
3. Dental treatment can be unpredictable. I acknowledge that no guarantee has been given as to the treatment results that may be obtained.
4. I consent to the proper disposal of any tissues or body parts that may be removed (i.e. tooth structure, mercury filling material, blood).
5. I acknowledge that the Notice of Privacy Practices is available and I may request a copy.
6. I grant my permission to Olya Banchik DDS to contact me to discuss matters related to this consent, my treatment or my account.
7. I hereby authorize Olya Banchik DDS to release any information necessary to process my dental insurance claims. I further authorize a release of information if necessary to refer my case to a specialist.
8. I hereby authorize all previously treating physicians to release my medical records to Olya Banchik DDS.
9. I understand that all responsibility for payment for dental services provided at Olya Banchik DDS for myself, or my dependents, is entirely mine, due and payable at the time services are rendered unless other arrangements have been made. I understand all deductibles and co-pays are required at time of service. Any dishonored checks will be assessed a statutory handling and collection fee of \$25 plus any bank related charges.
10. I hereby authorize and direct my insurance company to pay any dental benefits due to me directly to Olya Banchik DDS. I understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of this dental office.
11. I understand that appointment time is reserved specifically for me. It is my courtesy to provide 24 hours notice of any change in regards to scheduled dental appointments. Failure to provide this consideration will result in a \$50 charge.

---

Signature of Patient/Guardian

Date