PELICAN DENTAL REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:

Email address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred by:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

BACK TO PRACTICE

PATIENT CARE

California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 | cda.org

Covid-19 Patient Screening Form

Instructions for use: Use one form for each patient appointment. Ask the patient these questions at the time appointment is made or with appointment reminder, and again no more than two days before the appointment. Take the patient's temperature and note any signs of fever, coughing, or shortness of breath.

Patient/Parent/Guardian Names: ______________________________

Screening questions	Date: / / Staff initial:____	Date: / / Staff initial:____	Notes
Do you have a fever or above-normal temperature (>100.4° F)? *Take temperature at appointment.*	☐ No ☐ Yes	☐ No ☐ Yes	*If patient answers "yes" to either question on shortness of breath or coughing, or answers yes to any combination of two other symptoms and the patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve or until patient can provide proof they are not infectious for COVID-19. The dentist may want to seek additional information from the patient regarding symptoms.*
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a dry cough?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a runny nose?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a sore throat?	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have unexplained muscle pain?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a headache?	☐ No ☐ Yes	☐ No ☐ Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*If "yes" and patient does not need emergency care, do not see patient unless it has been more than 7 days since symptoms first appeared and 3 days of no fever without use of fever-reducing medication.*

Copyright © 2020 California Dental Association

Screening questions	Date: / / Staff initial:____	Date: / / Staff initial:____	Notes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*If yes, ask for date of last contact with COVID-positive patient and set appointment time for more than 14 days later, unless the patient needs emergency care.*
Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.*	☐ No ☐ Yes	☐ No ☐ Yes	
If yes, *what is the result of the testing?* ***If negative,*** *proceed to next question.* ***If still waiting on results,*** *schedule appointment after results are known.*	☐ No ☐ Unsure ☐ Positive	☐ No ☐ Unsure ☐ Positive	*If positive, determine if patient needs emergency care. If not an emergency, schedule patient to be seen when it has been more than 7 days since symptoms first appeared and 3 days of no fever without use of fever-reducing medication.*
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	*If yes, determine if patient traveled to an area where COVID-19 cases are high. Determine if patient followed physical distancing precautions and wore a mask while in public.Use professional judgement when determining whether to proceed with the appointment.*

Patient signature required at appointment:

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature____

CONFIDENTIAL HEALTH HISTORY

Patient Name: ______________________________ Date of Birth: ______________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: ______________________________
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: ______________________________
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: ______________________________
4. Yes / No Are you being treated by a physician now? If YES, explain: ______________________________
   Date of last medical exam? ____________ Reason for exam: ______________________
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: ______________________________
   Date of last dental exam: ____________ Name of last treating dentist: ______________________
6. Yes / No Are you in pain now?
   If YES, explain: ______________________________

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: ______________________________

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: ______________________________

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin
Yes / No Penicillin or other antibiotics
Yes / No Nitrous oxide
Yes / No Metal
Yes / No Valium or sedatives
Yes / No Latex
Yes / No Local anesthetic
Yes / No Codeine or other opioids
Yes / No Food

Others: ____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Anti-Depressants
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Herbal supplements
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin
Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: ____________________________

Please list all prescription medications: ____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? ______________________________
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ____
____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: ______________________________
Yes / No Have you ever taken Fen-Phen? If YES, when: ______________________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______________________________ Date: ______________________

Physician's Name: ______________________________ Phone Number: ______________________

Whom would you like us to contact in case of an emergency?):

Name: ______________________ **Relationship:** ____________________ **Phone Number:** _____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________ ______________________________ ______________
Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

Patient Form

healthystart®

Doctor/Dentist: ______________________________

Patient's Name: ______________________________ DOB: ______________ Age: ______

Relationship to Patient: ____________________ Pediatrician: __________________________

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dated at first appointment and the follow-up score column should be evaluated and dated after 3 months of treatment by the same person who filled out the initial assessment.

Date of Initial Assessment: ______________ **Date of Follow-up Assessment:** ______________

Filled Out By: ______________________ **Filled Out By:** ______________________

Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5

	INITIAL SCORE	FOLLOW-UP SCORE	
1.	_____	_____	Snoring of any kind
2.	_____	_____	Snores only infrequently (1 night/ week)
3.	_____	_____	Snores fairly often (2-4 nights/ week)
4.	_____	_____	Snores habitually (5-7 nights/week)
5.	_____	_____	Has labored, difficult, loud breathing at night
6.	_____	_____	Has interrupted snoring where breathing stops for 4 or more seconds
7.	_____	_____	Has stoppage of breathing more than 2 times in an hour
8.	_____	_____	Hyperactive
9.	_____	_____	Mouth breathes during day
10.	_____	_____	Mouth breathes while sleeping
11.	_____	_____	Frequent headaches in morning
12.	_____	_____	Allergy symptoms*: ☐ Asthma ☐ Eczema ☐ Nasal congestion ☐ Other: __________
13.	_____	_____	Excessive sweating while asleep
14.	_____	_____	Talks in sleep
15.	_____	_____	Poor ability in school*: ☐ Math ☐ Science ☐ Spelling ☐ Reading ☐ Writing

*Please indicate with a ☒ if condition is present

	INITIAL SCORE	FOLLOW-UP SCORE	
16.	_____	_____	Falls asleep watching TV
17.	_____	_____	Wakes up at night
18.	_____	_____	Attention deficit
19.	_____	_____	Restless sleep
20.	_____	_____	Grinds teeth
21.	_____	_____	Frequent throat infections
22.	_____	_____	Frequent ear infections
23.	_____	_____	Feels sleepy and/or irritable during the day
24.	_____	_____	Has a difficult time listening and often interrupts
25.	_____	_____	Fidgets with hands or does not sit quietly*: ☐ Muscular tics ☐ Restless (wiggles) legs
26.	_____	_____	Ever wets the bed
27.	_____	_____	Exhibits bluish color at night or during the day
28.	_____	_____	Nightmares and/or night terrors
29.	_____	_____	Exhibits any of the following*: ☐ Rarely smiles ☐ Feels sad ☐ Feels depressed
30.	_____	_____	**Speech problems****

**If scored greater than 0, please continue to Speech Questionnaire on page 2 (reverse side)

Was the 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

© by Ortho-Tain®, Inc. 2019

Revised 10/2019

Patient Form

Continued from question #30 on reverse side

healthystart®

Speech Questionnaire for Children

Not Present: 0 | Very Mild: 1 | Mild: 2 | Moderate: 3 | Pronounced: 4 | Severe: 5

Speech Assessment

	INITIAL SCORE	FOLLOW-UP SCORE	
1.	_____	_____	Do you or do others have difficulty understand your child's speech?
2.	_____	_____	Difficult to understand over the phone
3.	_____	_____	Uses grunts or screams more than words
4.	_____	_____	Lisp
5.	_____	_____	Hoarseness
6.	_____	_____	Nasal speech
7.	_____	_____	Becomes frustrated when attempting to speak
8.	_____	_____	Often uses words with only 1 or 2 syllables
9.	_____	_____	Seems winded when increasing volume
10.	_____	_____	Any difficulty in swallowing
11.	_____	_____	Stutters Any family history of a stutter? ☐Yes ☐No
12.	_____	_____	Tourette's Syndrome
13.	_____	_____	Family history of a speech or language disorder
14.	_____	_____	Any speech therapy? If so, how long? __________

Specific Articulation Questions

	INITIAL SCORE	FOLLOW-UP SCORE	
1.	_____	_____	Child replaces a "t, d, n, s, z, th or l" with a "p, b, m, w, f, or v" Example: "hap" for "hat", "kif" for "kiss", "fum" for "thumb", or "bav" for "bath"
2.	_____	_____	Child replaces an "r" with a "w" or an "L" with a "w" or a "y" Example: "wabbit" for "rabbit", " "yewo" for yellow" "weg" for "leg", "pway" for "play", "wun, for "run"
3.	_____	_____	Child replaces a "s, f, v, z, th, j, or h" with a consonant such as "p, b, t, d, k, g" Example: "tock" for "sock", "dump" for "jump", "pan" for fan", "bat" for "fat"
4.	_____	_____	Child replaces a "p, b, m, w, th, f, or v" with a "t, d, s, z, n, or l" Example: "sum" for "thumb", "muhzer" for "mother"
5.	_____	_____	Child replaces a "t" or a "d" with "k" or "g" Example: "gog" for "dog", "cop" for "top", "boke" for "boat", "key" for "tea"
6.	_____	_____	Child replaces a "ch" or a "j" sound with a "sh, v, f, th, or s" Example: "ship" for "chip", "shoo shoo" for "choo choo"
7.	_____	_____	Child changes position of a sound within a word Example: "pasghetti" for "spaghetti", "efelant" for "elephant", "baksit" for "basket"
8.	_____	_____	Child inserts "uh" into words Example: "stuh-reet" for "street", "fuh-wog" for "frog", "buh-lue" for "blue", "puh-lease" for "please"
9.	_____	_____	Child replaces a "k" or a "g" with "t" or "d" Example: "doat" for "goat", "tuhtie" for "cookie", "tup" for "cup", "hud" for "hug"
10.	_____	_____	Child replaces a "sh" with an "s" Example: "sue" for "shoe", "sip" for "ship", "mezza" for "measure"

Based on Bauman-Waegler, J.A. 2012, Bernthal, et al. 2013, Bowen 1998, and Grunwell 1997

© by Ortho-Tain®, Inc. 2019

Revised 10/2019

Patient Responsibility form

Patient Name:________________________________Date:__________________

We are pleased to assist you with your dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Co-pays:
I understand that I am responsible to pay all co-payment at the time of service, prior to leaving.

Deductible:
If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

____

Patient Signature/Guardian Date