Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

# PATIENT REGISTRATION

**We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.**

Today's Date: _____

## ABOUT YOU

**First Name:** _____ MI: _____ **Last Name:** _____

I prefer to be called: _____ Preferred Pronoun: _____

Gender: ☐ Male ☐ Female ☐ Other

Birthdate: _____

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated ☐ Partnered

Address: _____ Apt #: _____

City: _____ State: _____ ZIP: _____

Hm #: _____ Mobile #: _____ Email Address: _____

Wk #: _____ Ext: _____

Preferred Contact Method: ☐ Home Phone ☐ Mobile Phone ☐ Email
☐ Work Phone ☐ Mobile Text Message

Employer: _____

Occupation: _____

**Person Responsible for Account:**

_____

Whom may we thank for referring you? _____

Other family members seen by us: _____

☐ Previous Dentist / ☐ Present Dentist:
**(please check)**

_____

## EMERGENCY CONTACT

**Relative or Friend not living with you**

His/Her Name: _____

Relation: _____ Phone #: _____

## INSURANCE COVERAGE

**PRIMARY DENTAL**

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group Name: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

What is your relationship to the Insured?

☐ Self ☐ Spouse ☐ Significant Other ☐ Child

Insured's Birthdate: _____

Insured's ID #: _____

Insured's Employer: _____

**SECONDARY DENTAL**

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group Name: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

What is your relationship to the Insured?

☐ Self ☐ Spouse ☐ Significant Other ☐ Child

Insured's Birthdate: _____

Insured's ID #: _____

Insured's Employer: _____

**MEDICAL INSURANCE**

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group Name:

Group # (Plan, Local or Policy #):

Insured's Name:

What is your relationship to the Insured?

☐ Self ☐ Spouse ☐ Significant Other ☐ Child

Insured's Birthdate:

Insured's ID #:

Insured's Employer:

---

Signature

Today's Date:

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative/Parent/Guardian's Name:

Relationship:

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# HEALTH HISTORY

**PATIENT** FIRST NAME | LAST NAME | BIRTHDATE

## MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Phone #: Date of last visit:

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one in the spaces below:
**(For patients updating in-office: Mark any medications that you are no longer taking and add any new ones.)**

☐ ☐
☐ ☐
☐ ☐

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

If so, when?

**FOR WOMEN:** Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:

Are you nursing? ☐ Yes ☐ No

**Have you ever had any of the following diseases or medical problems?**

- ☐ Abnormal Bleeding/ Hemophilia
- ☐ AIDS / HIV
- ☐ Alcohol/Drug Abuse
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lupus
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

**Are you allergic to any of the following?**

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

Please list any other drugs/materials that you are allergic to:

## DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

**Your current dental health is:** ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of toothbrush bristles? ☐ Soft ☐ Medium ☐ Hard

Have you had previous ortho treatment? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat or cold?

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Do you have dry mouth? ☐ Yes ☐ No

Have you chipped or fractured any teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

**Are you happy with the way your smile looks?** ☐ Yes ☐ No

If not, what would you change?

Patient/Guardian Signature Date:

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

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# Sleep Questionnaire

First Name: _____ Last Name: _____ Birthdate: _____

Height: _____ Weight: _____

## Chief Complaints

- [ ] None
- [ ] CPAP Intolerance
- [ ] Difficulty concentrating
- [ ] Excessive daytime sleepiness
- [ ] Fatigue
- [ ] Forgetfulness
- [ ] Frequent snoring
- [ ] Gasping causing waking up
- [ ] Impaired thinking
- [ ] Insomnia
- [ ] Witnessed cessation of breathing
- [ ] Morning headaches
- [ ] Unrefreshing sleep
- [ ] Nighttime choking spells
- [ ] Snoring which affects the sleep of others
- [ ] Witnessed cessation of breathing

Additional Complaints:

## Sleep Medical History

- [ ] None
- [ ] Acid reflux
- [ ] Anemia
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Autoimmune disorder
- [ ] Bleeding easily
- [ ] Blood pressure - High
- [ ] Blood pressure - Low
- [ ] Bruising easily
- [ ] Chronic fatigue
- [ ] Chronic pain
- [ ] COPD
- [ ] Coronary heart disease
- [ ] Depression
- [ ] Difficulty sleeping
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive daytime sleepiness
- [ ] Fibromyalgia
- [ ] Glaucoma
- [ ] Gout
- [ ] Hay fever
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart pacemaker
- [ ] Heart valve replacement
- [ ] Hemophilia
- [ ] High blood pressure
- [ ] Hypertension
- [ ] Hypoglycemia
- [ ] Immune system disorder
- [ ] Insomnia
- [ ] Ischemic heart disease (reduced blood supply)
- [ ] Meniere's disease
- [ ] Mitral valve prolapse
- [ ] Mood disorder
- [ ] Multiple sclerosis
- [ ] Muscular dystrophy
- [ ] Nasal allergies
- [ ] Neuralgia
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Parkinson's disease
- [ ] Restless Legs Syndrome
- [ ] Rheumatic fever
- [ ] Rheumatoid arthritis
- [ ] Sinus problems
- [ ] Sleep apnea
- [ ] Stroke
- [ ] Tendency for ear infections
- [ ] Tumors
- [ ] Urinary disorders
- [ ] Weight gain

Additional Medical History:

## Surgical History

- [ ] None
- [ ] Appendectomy
- [ ] Back
- [ ] Ear
- [ ] Gallbladder
- [ ] Heart
- [ ] Hernia repair
- [ ] Lung
- [ ] Nasal
- [ ] Periodontal
- [ ] Thyroid
- [ ] Tonsillectomy

Additional Surgical History:

## Family History

- [ ] None
- [ ] Cancer
- [ ] Heart disease
- [ ] Diabetes
- [ ] High blood pressure
- [ ] Stroke
- [ ] Sleep disorder
- [ ] Obesity
- [ ] Thyroid disorder
- [ ] Father snores
- [ ] Mother snores
- [ ] Father has sleep apnea
- [ ] Mother has sleep apnea

## Social History

### Tobacco/Nicotine Use

- [ ] Never Smoked
- [ ] Current Smoker _____ Packs/Day _____ Years
- [ ] Quit Smoking Quit Date _____

- [ ] Pipe
- [ ] Cigar
- [ ] Snuff
- [ ] Chew
- [ ] Vape

### Alcohol Use

Do you drink alcohol? Yes [ ] No [ ] _____ Drinks/Week

### Caffeine Intake

- [ ] None
- [ ] Coffee/Tea/Soda _____ Cups/Day

## Epworth Sleep Questionnaire

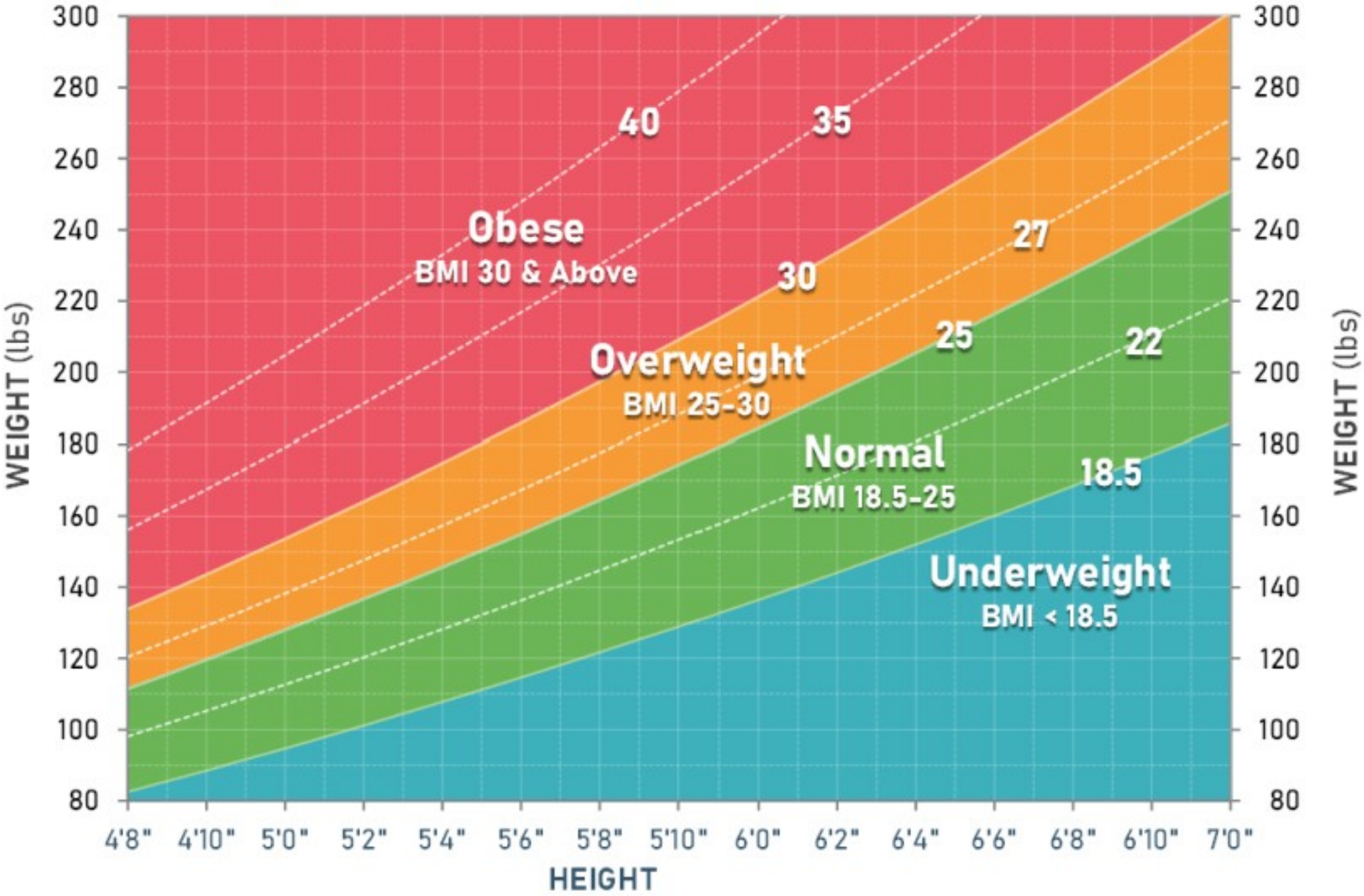
| | Never become drowsy (0) | Rarely become drowsy (1) | Frequently become drowsy (2) | Always become drowsy (3) |
|---|---|---|---|---|
| Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ |
| Sitting inactive in a public place (e.g. movie theatre) | ☐ | ☐ | ☐ | ☐ |
| As a passenger in the car for an hour without a break? | ☐ | ☐ | ☐ | ☐ |
| If you had the chance to lie down in the afternoon? | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch (which did not include alcohol)? | ☐ | ☐ | ☐ | ☐ |
| While talking to someone? | ☐ | ☐ | ☐ | ☐ |
| In a car while stopped for a few minutes in traffic? | ☐ | ☐ | ☐ | ☐ |

## STOP-BANG Questionnaire

| | Yes | No |
|---|---|---|
| Do you snore loudly (louder than talking or loud enough to be heard through closed door)? | ☐ | ☐ |
| Do you often feel tired, fatigued, or sleepy during daytime? | ☐ | ☐ |
| Has anyone observed you stop breathing during your sleep? | ☐ | ☐ |
| Do you have or are you being treated for high blood pressure? | ☐ | ☐ |
| Age over 50 years old? | ☐ | ☐ |
| Neck circumference greater than 15.7 inches (40 cm)? | ☐ | ☐ |
| Is your gender male? | ☐ | ☐ |
| Body Mass Index (BMI) more than 35? | ☐ | ☐ |

Use the chart below (or an online calculator) to estimate your BMI: _____

# Body Mass Index (BMI) Chart for Adults



## Sleep History

☐ Previously diagnosed with Obstructive Sleep Apnea (OSA)? When: _____

### Snoring

Frequency: ☐ Never ☐ Seldom ☐ Often ☐ Daily

Severity: ☐ Light ☐ Moderate ☐ Loud

☐ Worse when sleeping on your back

☐ Worse following alcohol late at night

### Witnessed Apneas

☐ Worse when sleeping on your back

☐ Worse following alcohol late at night

### Sleep

How long does it take you to fall asleep? _____ minutes

Normally goes to bed at: _____ Sleep per night: _____ hours

☐ Sleep Aid? _____

☐ Racing thoughts while waiting to fall asleep?

### Patient Reports

☐ Bruxism (grinding teeth)

☐ Dry mouth

☐ Excessive movements

☐ Gasping

☐ Getting up (# of times) per night _____ times

☐ Restless legs

☐ Waking up and having difficulty returning to sleep

☐ Dreaming

☐ Vivid dreams and/or waking up feeling paralyzed

### Waking

☐ Awaken unrefreshed

☐ With morning headaches

☐ With heartburn

☐ Sleepiness while driving

☐ Sudden loss of strength in arms or legs triggered by laughter or fright?

### Naping

Frequency: ☐ Daily ☐ Occasional ☐ Never

## CPAP Intolerance

☐ None

☐ Refuses CPAP

☐ CPAP restricted movements during sleep

☐ Does not resolve symptoms

☐ Discomfort from headgear

☐ Disturbed or interrupted sleep

☐ Noise disturbing sleep and/or bed partner's sleep

☐ An unconscious need to remove the CPAP

☐ Mask leaks

☐ Pressure on the upper lip causing tooth related problems

☐ Latex allergy

☐ CPAP does not seem to be effective

☐ Inability to get the mask to fit properly

☐ Claustrophobic associations

☐ Noisy

☐ Cumbersome

## Other Therapy Attempts

- [ ] Dieting
- [ ] Weight loss
- [ ] Surgery (Uvuloplasty)
- [ ] Uvuloplasty (but continues to have symptoms)
- [ ] Surgery (Uvulectomy)
- [ ] Uvulectomy (but continues to have symptoms)
- [ ] Pillar procedure
- [ ] Smoking cessation
- [ ] CPAP
- [ ] BiPAP
- [ ] Positional therapy (side sleeping)
- [ ] Nasal strips

## Treatment History

List any treatments you have had for this problem and all health professionals that you are currently seeing. (Approximate Date, Treatment, Specialty, Practitioner's Name)

Signature

Today's Date:

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____

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# Consent Form

First Name: _____ Last Name: _____ Birthdate: _____

We are honored that you have selected us to provide dental care for you.

I, _____ give consent for myself/my child to receive dental treatment deemed necessary by the doctors and staff at Ghina Morad, DMD. These procedures include, but are not limited to; examinations, x-rays, oral prophylaxes, fluoride treatments, sealants, restorations such as composite fillings and crowns, periodontal treatments, endodontic (root canal) treatments, extractions,orthodontic treatments, and the use of local anesthetics. This consent shall be considered in effect until rescinded or revoked.

**Changes in Treatment Plan:**

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

**Risk of Dental Procedures:**

May Include but are not limited to, complications resulting from the use of dental instruments, drugs, medicines, analgesics, anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular jaw (TMJ) joint difficulty and injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

**Release of Photos:**

I understand the use of photos, videos, or other images taken may be used by Ghina Morad, DMD, using my name or a fictitious name in media form. I release any and all claims whatsoever in connection with the use of my photography, name and reproduction of material.

**Audio Recording:**

I understand that for quality assurance and training purposes, audio recording devices are used in this practice. These are used for progress notes summaries and perio charting. If you do not consentT to being recorded, please notify the front desk so that alternative arrangements can be made.

**For children under the age of 18:**

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize the release of information for my child to these parties:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Comments: _____

**By signing this Consent Form, I have read, understand and agree to the terms and conditions.**

Signature

Today's Date:

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

# Financial Agreement

First Name: _____ Last Name: _____ Birthdate: _____

Thank you for choosing us as your dental care provider. We are committed to providing you with the best experience possible. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

**PAYMENT:**

The patient's portion (whatever the insurance is not expected to cover) is due at the time of service unless other payment arrangements have been made with the Financial Manager. For more extensive treatments, financing options are available and multiple options will be offered to help you complete your treatment in full. In the event payment is not received on the agreed upon date, a finance charge will be applied. If the insurance pays more than we estimated, the excess will be refunded to you.

**INSURANCE:**

**You should be aware that Insurance companies base their coverage on a fixed fee schedule that may not coincide with our fees. Furthermore, they might change their restrictions without any previous notice to us or to you.**

Our staff will gladly try to determine your insurance coverage to the best of their ability and prepare all the forms to bill your insurance for you as a courtesy on your behalf. After 60 days of being billed, if your insurance has not paid, the insurance balance will become your responsibility.

**Additionally, should your insurance benefits result in less coverage than anticipated, you are still fully responsible for the full fee of the treatment.**

**MISSED APPOINTMENTS:**

Unless we receive notice of cancellation two business days prior to scheduled treatment, you will be charged the cancellation fee. Please help us service you better by keeping scheduled appointments and be aware that by failing to attend your appointment, you are taking the time from another patient who possibly needed that time.

**By signing this Financial Agreement, I have read, understood, and have agreed to all these terms and conditions.**

Signature

Today's Date: _____

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____

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# Notice of Privacy Policies

First Name: _____ Last Name: _____ Birthdate: _____

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

## Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

## Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

## Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

* Conditions and limitations may apply; obtain additional information from front desk.

As my Dental Care provider, I give my permission to contact me or leave a confidential voicemail for myself on my:

☐ Home phone ☐ Moble phone ☐ Work phone

I give my permission to contact me or leave a confidential message for myself via email.

☐ Yes ☐ No

Date:

Signature

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name:

Relationship:

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# Dental Material Fact Sheet Acknowledgement

First Name: _____ Last Name: _____ Birthdate: _____

As of January 1, 2002, the Dental Board of California requires that we distribute to our patients a copy of The Dental Material Fact Sheet. This is available from our front desk staff upon your request. Please sign below acknowledging your right to review this information.

| | |
|---|---|
| | Today's Date: _____ |

Signature

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____