Alisa Reed, DDS Cosmetic & Family Dentistry
1001 Medical Plaza Dr- Suite 300 The Woodlands, TX 77380
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Patient Information

Last:_____ First:_____ Middle Initial: _____
Address:_____City:_____ State:_____ Zip:_____
Social Security#_____ Sex: ☐ M ☐ F Age:_____ Birthdate:_____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Cell Phone: _____ Work Phone: _____ Home: _____
Email:_____
Patient Employed by:_____ Occupation:_____
Business Address:_____ Work Email:_____
Whom may we thank for referring you? _____
Who shall we notify in the case of an emergency: _____
Email:_____ Cell Phone # _____ Other Phone# _____

Primary Insurance (*Person Responsible for Account*)

Last Name: _____ First Name: _____ Middle Initial: _____
Relation to Patient: _____ Birthdate: _____ Social Security#_____
Address:(*if different from patient)*_____
City: _____ State:_____ Zip:_____
Home Phone _____ Cell: _____Email:_____
Person Responsible Employed by: _____ Occupation: _____
Business Email: _____ Business Phone #_____
Insurance Company: _____ Phone #_____
Group # _____ Subscriber #_____
Name of other dependents under this plan: _____

Dental History

What would you like to be seen for today?_____
Are you in dental discomfort today? _____
Former Dentist:_____ Address:_____
Dentist's Phone:_____ Email:_____
Date of last dental care:_____ Date of last x-rays:_____

Please Check Box (√) if any apply to you:

☐ Bad Breath
☐ Bleeding gums
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sores or growths in mouth
☐ Periodontal treatment
☐ Grinding or clenching teeth
☐ Clicking or popping jaw
☐ Loose teeth or broken fillings
☐ Food collection between teeth
☐ Loose teeth or broken fillings
☐ Sensitivity to sweets
☐ Sensitivity when biting

How often do you brush? _____

How often do you floss? _____

How do you feel about the appearance of your teeth? _____

_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

_____

Other information about your dental health or previous treatment: _____

_____

Medical History

Physician's name:_____ Phone#_____

Date of last visit:_____

Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe:_____

Are you currently under physician care? ☐ Y ☐ N If yes, describe: _____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates: _____

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Please Check Box (√) if any apply to you:

☐ AIDS/HIV Positive
☐ Anaphylaxis
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Joints
☐ Asthma
☐ Back problems
☐ Heart Valves (Artificial)
☐ Blood disease
☐ Cancer-Describe _____
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Food Allergies
☐ Glaucoma
☐ Headaches
☐ Heart Murmur/Pacemaker
☐ Heart Problems
☐ Heart surgery
☐ Herpes
☐ Hepatitis
☐ High Blood Pressure
☐ Jaw pain
☐ Kidney disease/malfunction
☐ Liver disease ☐ Tuberculosis
☐ Material Allergies (latex wool, metal, chemicals
☐ Mitral valve prolapse
☐ Nervous Problems
☐ Psychiatric care
☐ Radiation treatment
☐ Rapid weight gain or loss
☐ Respiratory disease
☐ Rheumatic/Scarlet Fever
☐ Shingles
☐ Shortness of breath
☐ Skin Rash, Allergies
☐ Stroke
☐ Surgical Implant
☐ Swelling of feet or ankles
☐ Thyroid disease or malfunction
☐ Tobacco habit
☐ Ulcer/Colitis
☐ Venereal disease
☐ Other: _____

Does patient have any allergies? ☐ Y ☐ N If Yes, list all: _____

_____

Is patient currently taking any medications? ☐ Y ☐ N If Yes, list all: _____

_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

- *This refers to your usual way of life in recent times.*
- *Even if you haven't done some of these things recently try to work out how they would affect you.*

1. Sitting and Reading Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing		2. Watching TV Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing
3. Sitting, inactive in a public place (e.g. a theatre or meeting) Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing		4. As a passenger in a car for an hour without a break Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing
5. Lying down to rest in the afternoon when circumstance permits Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing		6. Sitting and taking to someone Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing
7. Sitting quietly after a lunch without alcohol Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing		8. In a car, while stopped for a few minutes in the traffic Choose one ☐ 0= would never doze ☐ 1=slight chance of dozing ☐ 2=moderate chance of dozing ☐ 3=high chance of dozing

☐ Y ☐ N Ever been diagnosed with Sleep Apnea?

☐ Y ☐ N Do you snore? If YES, indicate level;

☐ Quiet ☐ Light ☐ Loud ☐ Epic

☐ Y ☐ N Does your snoring occur almost every night?

☐ Y ☐ N Do you feel that in some way your sleep is not refreshing or restful?

☐ Y ☐ N Do you wake up in the night or in the morning with a head ache?

☐ Y ☐ N Do you experience fatigue during the day and have difficulty staying awake?

☐ Y ☐ N Do you have trouble remembering things through the day?

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me to services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Alisa M. Reed D.D.S.
ACKNOWLEDGEMENT OF RECEIPT OF
HIPPA NOTICE OF PRIVACY PRACTICES

I ACKKOWLEDGE THAT I HAVE RECEIVED A COPY OF THE WOODLANDS DENTAL GROUP'S NOTICE OF PRIVACY PRACTICES.

Patient Name: _____ Date: _____

Authority of Personal Representative to Sign for Patient (check one)

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other

If you checked OTHER, please indicate: _____

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT

DENTAL OFFICE USE ONLY

We attempted to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

_____ An emergency prevented us from obtaining acknowledgement.
_____ A communication barrier prevented us from obtaining acknowledgement.
_____ The Individual refused to sign.
_____ Other: _____

_____ Date: _____

Office Member Signature