Dr. Nina Thomas • 1440 Brogden Woods Dr., Ste. 101 • Wake Forest, NC 27587 • 919-888-4809 • LongleafDentist.com

W E L C O M E

Please fill out these pages completely. We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

Full legal name:_____

I prefer to be addressed as: _____

Circle One: Male Female Birthdate: _____

SSN (REQUIRED): _____

Address: _____

City:_____State:_____ Zip: _____

Email Address: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Occupation:_____

Other Family Members Seen by Us:_____

How did you hear about us?: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

MEDICAL HISTORY

Although we primarily treat the mouth, your mouth is a part of your entire body. Health conditions that you have or medications that you are taking could have an important relationship with the dentistry you will receive. Thank you for answering the following questions completely.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (mark YES or NO for every item below)

Heart Attack/Failure	□YES □NO	Chest Pains	□YES □NO	Heart Trouble/Disease	□YES □NO	Recent Weight Loss	□YES □NO
Currently Pregnant	□YES □NO	Cold Sores/Fever		Hemophilia	□YES □NO	Rheumatic Fever	□YES □NO
Pacemaker	□YES □NO	Blisters	□YES □NO	Hepatitis A	□YES □NO	Rheumatism	□YES □NO
Shingles	□YES □NO	Congenital Heart		Hepatitis B or C	□YES □NO	Scarlet Fever	□YES □NO
Stroke	□YES □NO	Disorder	□YES □NO	Herpes	□YES □NO	Sleep Apnea	□YES □NO
Tuberculosis	□YES □NO	Cortisone Medicine	□YES □NO	High Blood Pressure	□YES □NO	Sickle Cell Disease	□YES □NO
AIDS/HIV Positive	□YES □NO	Diabetes	□YES □NO	High Cholesterol	□YES □NO	Sinus Trouble	□YES □NO
Alzheimer's Disease	□YES □NO	Drug Addiction	□YES □NO	Hives or Rash	□YES □NO	Sleep Apnea	□YES □NO
Anaphylaxis	□YES □NO	Dry Mouth	□YES □NO	Hypoglycemia	□YES □NO	Spina Bifida	□YES □NO
Anemia	□YES □NO	Easily Winded	□YES □NO	Irregular Heartbeat	□YES □NO	Stomach/GI Disease	□YES □NO
Angina	□YES □NO	Emphysema	□YES □NO	Kidney Problems	□YES □NO	Swelling of Limbs	□YES □NO
Arthritis	□YES □NO	Epilepsy or Seizures	□YES □NO	Leukemia	□YES □NO	Thyroid Disease	□YES □NO
Artificial Heart Valve	□YES □NO	Excessive Bleeding	□YES □NO	Liver Disease	□YES □NO	TMJ/Pain in Jaw Joints	□YES □NO
Artificial Joint	□YES □NO	Fainting/Dizziness	□YES □NO	Low Blood Pressure	□YES □NO	Tonsillitis	□YES □NO
Asthma	□YES □NO	FIbromyalgia	□YES □NO	Lung Disease	□YES □NO	Tumors or Growths	□YES □NO
Blood Disease	□YES □NO	Frequent Cough	□YES □NO	Mitral Valve Prolapse	□YES □NO	Ulcers	□YES □NO
Breathing Problem	□YES □NO	Frequent Headaches	□YES □NO	Osteoporosis	□YES □NO		
Bruise Easily	□YES □NO	Glaucoma	□YES □NO	Parathyroid Disease	□YES □NO		
Cancer	□YES □NO	Head/Neck Injury	□YES □NO	Psychiatric Care	□YES □NO		
Chemotherapy	□YES □NO	Heart Murmur	□YES □NO	Radiation Treatments	□YES □NO		

Any serious illness not discussed above? □YES □NO If yes, please explain:_____

Are you allergic to any of the following? □Tylenol (Acetaminophen) □Penicillin □Codeine □Local Anesthetics □Acrylic □Metal □Latex □Other

If yes, please explain:_____

Are you under a physician's care now? □YES □NO If yes, please explain:_____

Hospitalizations/Operations? □YES □NO If yes, please explain:_____

Have you ever had treatment for cancer? □YES □NO If yes, please explain:_____

Have you ever taken bisphosphonates? (medications for bone health) □YES □NO If yes, please explain:_____

Tobacco use? □YES □NO If yes, please explain:_____

Controlled Substance? □YES □NO If yes, please explain:_____

Women: Are you Pregnant/Trying? □YES □NO
Taking oral contraceptives? □YES □NO
Nursing? □YES □NO

W E L C O M E

List all medications/supplements: _____

_____

_____

_____

SLEEP QUESTIONNAIRE

Sleep can be affected significantly by the shape of your teeth, tongue, mouth, and throat. This can affect your health and well-being in many significant ways, and you may not even be aware of it. Thank you for answering the following questions completely.

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 have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

CHANCE OF DOZING	SITUATION
_____	Sitting and reading
_____	Watching TV
_____	Sitting inactive in a public place (e.g a theater or a meeting)
_____	As a passenger in a car for an hour without a break
_____	Lying down to rest in the afternoon when circumstances permit
_____	Sitting and talking to someone
_____	Sitting quietly after a lunch without alcohol
_____	In a car, while stopped for a few minutes in traffic

Do you snore loudly?	□YES □NO □NOT SURE
Do you often feel tired, fatigued, or sleepy during daytime?	□YES □NO □NOT SURE
Has anyone observed you stop breathing during your sleep or waking up with a gasp?	□YES □NO □NOT SURE
Do you grind/clench your teeth?	□YES □NO □NOT SURE
Do you have restless legs/the urge to get up at night?	□YES □NO □NOT SURE
Do you get up to urinate during the night?	□YES □NO □NOT SURE

ACKNOWLEDGEMENTS & SIGNATURES

- I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.
- I understand that providing incorrect information can be dangerous to my (or patient's) health.
- I understand that I will be required to pay my estimated portion of Dr. Thomas' fees at the time of scheduling. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.
- A no show fee of $50.00 will be charged for appointments cancelled without 48 hours' notice.
- I authorize Dr. Thomas and Longleaf Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to Dr. Thomas and Longleaf Dentistry insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

Signature of patient or parent/guardian, if minor:_____ Date: _____

W E L C O M E

CONSENT

Thank you for choosing Longleaf Dentistry for your dental care. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- Allergic reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
- Long-term numbness (paresthesia). Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness, pain, or tingling.
- Muscle or joint tenderness: Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- Sensitivity in teeth or gums, infection, or bleeding.
- Swallowing or inhaling small objects.

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

My signature below indicates that I have read and understand the general risks associated with dental treatment.

Signature of patient or parent/guardian, if minor: _____

Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient:_____

Signature:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____Initials:_____

Reason: _____