WELCOME TO OUR PRACTICE TODAY'S DATE_____

NAME_____ Birthdate _____ Social Security No._____

MAILING ADDRESS _____City _____ State _____ Zip _____

What name would you like to be called? _____D.L.# _____ Marital Status _____

Spouse's Name _____ E-mail address_____ Employer_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____

(

Phones: Home _____ Work _____ Fax_____

Cell _____ Pager _____ Other_____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME _____

Their Social Security No. _____Birth date _____Mailing Address _____

Daytime Phone _____

INSURANCE INFORMATION

Insured's Name_____ Member ID No._____ Employer_____

Ins Co._____Group #_____ Insured's Birthdate _____Phone#_____

Insurance Co. Address_____

Emergency contact: _____ Relation _____ Phone: _____

HEALTH HISTORY **(please check if you have or had any of the following:)**

__Yes	__No	Are you in good health?	__Yes	__No	TB, asthma, or lung disease?
__Yes	__No	Has your health changed in the last year?	__Yes	__No	Diabetes
__Yes	__No	Chest pain, shortness of breath	__Yes	__No	Tumors, cancer
__Yes	__No	Bleeding problems, bruise easily	__Yes	__No	Radiation treatment
__Yes	__No	Headaches, ringing in ears	__Yes	__No	Psychiatric care
__Yes	__No	Joint pain or stiffness, arthritis	__Yes	__No	Kidney or bladder disease
__Yes	__No	Fainting or seizures	__Yes	__No	VD, herpes
__Yes	__No	Heart disease, murmurs, prolapse, rheumatic fever, prosthetic heart valve	__Yes	__No	HIV positive, AIDS, ARC
			__Yes	__No	Hepatitis or liver disease
__Yes	__No	Pacemaker	__Yes	__No	Pregnant: month_____
__Yes	__No	High blood pressure	__Yes	__No	Birth Control Pills
__Yes	__No	Tobacco/alcohol	__Yes	__No	Osteoporosis?
__Yes	__No	Recreational drugs	__Yes	__No	Taking bisphosphonates?
			__Yes	__No	Allergic to metals or latex?

List any and all ALLERGIES: _____

List any and all DRUGS/MEDICATIONS you are taking: _____

List any and all Surgeries_____

__Yes __No Are you being treated by a Doctor now? Who? _____

I have read my MEDICAL HISTORY dated _____and confirm that it states past and present conditions.

Date:	Exceptions:		Patient's Signature
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____
_____	_____	☐ None	_____

RANDALL L. FOTO, D.D.S.
FAMILY DENTISTRY

645 B Lotus Drive North
Mandeville, LA 70471
985.626.4447 • www.ident.ws/fotofordental

Chart #: _____
FOR OFFICE USE ONLY

DENTAL HISTORY

Name _____ Birthdate _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____ Fax _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (waterpik, electric toothbrush, etc.) _____

Are there any areas of your mouth difficult to clean? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

_____

Are any of your teeth sensitive to:		
Sweets, Hot or cold?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Notice excessive wear on your teeth?	Yes	No
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails)	Yes	No
Have frequent dry mouth?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/Chew tobacco or use other tobacco products?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Gum treatment?	Yes	No
Your bite adjusted?	Yes	No
A bite plate, splint, or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
Have you ever experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of mouth?	Yes	No
Headaches, neckaches or shoulder aches?		
Sore muscles (neck, shoulders)?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Would you like to improve the appearance of your teeth/smile?	Yes	No
Does your diet include:		
Soft drinks	Yes	No
amount per day_____		
Frequent mints, candies or gum	Yes	No

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

_____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name	
				Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: **Male** ◯ **Female** ◯
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score ☐

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
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 lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score ☐

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

Assign points for each of the first three responses

☐
☐
☐

Signature	Area Code / Phone Number	**Total all 6 boxes from above** If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	**Point Total** ☐

APPOINTMENTS

Because we recognize the value of your time, you can expect us to see you at the appointed times, so as to keep your time spent in our office as short as possible. Likewise, when you make an appointment with us, we have reserved our times just for you and ask that you be on time. If you cannot keep your appointment, we ask you to give us **at least 48 hours notice** so that we can give your time slot to another patient. Otherwise, our office policy is to charge an hourly rate to help defer some of the overhead expense associated with not having a patient scheduled in your time slot. We believe very strongly that mutual trust and respect for each other's time will strengthen our relationship.

FINANCIAL POLICY

- Unless another financial option is pre-arranged, payment in full is due the day of treatment.
- For procedures requiring long appointment times, 1/3 of the payment is expected to reserve the appointment time.

PAYMENT OPTIONS

1. For your convenience we accept Cash, Check, Visa, MC, Discover and AE.
2. A 5% discount is offered for any treatment plan paid in full at the time the appointment is made.
3. We also offer short and long-term financing through Care Credit and Lending Club.

FOR PATIENT WITH DENTAL INSURANCE

- As a courtesy, we will accept assignment of your insurance benefits provided we are able to verify current coverage and have received a copy of your insurance card or a signed, completed dental insurance form.
- We will estimate your insurance benefits and will expect your portion of the fee to be paid at each visit. You are responsible for any portion your insurance company does not cover. If for any reason your insurance company pays less than what was estimated, you will be responsible for the unpaid balance.
- If the balance is not paid within 30 days of the billing date, a finance charge of 1.5% per month will be added to the account. In case of default of payment, you will be responsible for any interest on the balance due, together with any collection costs and reasonable attorney's fees incurred in the collection of this account.

AUTHORIZATION AND CONSENT

GENERAL CONSENT TO TREATMENT

I agree and consent to a dental examination by Dr. Foto. I understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

RELEASE OF INFORMATION

I authorize Dr. Foto to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize and request my insurance company to pay my benefits directly to Dr. Foto.

PHOTOGRAPHY RELEASE

I authorize Dr. Foto to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

My signature acknowledges that:

I understand the office policy with keeping Appointments.
I understand and will comply with the office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
I assign my insurance benefits to Dr. Foto.
Photographs taken of me may be shown to other patients.
I have received a copy of this office's Notice of Privacy Practices.

X_____ Date_____

Signature of Patient, Parent or Guardian

RECORDS RELEASE REQUEST

TO: _____

Address:_____

City:_____State:_____Zip_____

To enable me to continue my dental care without any undue delays, I hereby authorize that my dental records and X-rays or copies of such be transferred to:

Randall L. Foto, D.D.S.
645 Lotus Drive North
Suite B
Mandeville, LA 70471-3301
fotofordental@gmail.com
985-626-4447 fax: 985-674-6688

Thank you for your immediate attention to my request. It is greatly appreciated.

Print name of patient as it appears on requested records:

_____

Patient's Signature _____

Date: _____