Welcome to the office of Dr. Renee Corbitt

Purpose of this visit_____ Date_____
Name_____ Sex: F _____ M _____
Address_____City_____Zip_____
Home email _____
Home Phone (_____) _____Cell Phone (_____) _____
Work Phone (_____) _____

Patients are reminded of appointments by automated text or email reminders only.
What type of reminders would you like to receive email _____ and/or text _____?

Date of Birth_____ Age_____ Marital Status _____ Height_____ Weight_____
SS# _____ Driver's License #_____ State _____

Your Employer_____ Occupation_____
Address _____ City_____ Zip _____
Work Email _____

Spouse or Responsible Party's Name_____ Relationship _____
Employer _____ Occupation_____
Address _____ City _____ Zip _____
Home Phone # _____ Work Phone # _____

Emergency Contact Name_____Relationship_____
Address _____ City _____ Zip _____
Home Phone # _____ Work Phone # _____

How were you referred to the office? _____
Former dentist_____

Insurance Information

Are you covered by dental insurance? Yes _____ No _____

You are responsible for *all* charges incurred regardless of any insurance coverage or payment. We are not contracted with your insurance carrier. If we file your insurance, you are required to pay your estimated portion at the time services are rendered. We must have verified your insurance coverage in order to file your insurance. Initials_____

Primary Insurance:
Name of Insured_____
Insured's employer_____
Insured's SS#_____
Date of birth_____
Relationship to insured_____
Name of Insurance Co. _____
Group/Plan #_____

Secondary Insurance:
Name of Insured_____
Insured's employer_____
Insured's SS#_____
Date of birth_____
Relationship to insured_____
Name of Insurance Co. _____
Group/Plan #_____

Dental Information

How would you describe your current dental health? _____
Date of your last dental visit and what was done: _____
Have you had any difficulty with dental treatment in the past? Yes _____ No _____
Please explain._____
_____
Have you ever had an injury to your face or jaws? _____
Do you have any popping, clicking or pain of your tempromandibular joint? Yes_____ No_____
If yes, please explain._____

Would you like nitrous oxide (laughing gas) with treatment? Yes _____ No _____
Would you like sedation for your dental treatment? Yes _____ No _____

Is there anything about your teeth or smile that you would like to change? Yes _____ No ____
If yes, please explain._____
_____
_____

Do you have or have had a history of any of the below, please circle Y or N.

Y	N	bleeding gums when you brush	Y	N	nail biting
Y	N	had orthodontic treatment (braces)	Y	N	food collection areas
Y	N	loose teeth	Y	N	difficulty with swallowing
Y	N	bad breath	Y	N	cold sores (fever blisters)
Y	N	biting hard objects (pens, etc.)	Y	N	apthous ulcers
Y	N	oral piercing(s)			

Y N wears removable appliances (retainer _____ partial(s)_____ or denture(s)_____)
Y N periodontal treatment (deep cleaning or gum surgery) if so when? _____

How many times a day do you brush? _____
How many times a day do you floss? _____ A week? _____
Do you use a manual toothbrush Soft? _____ Medium? _____ Hard? _____
Do you use an electric toothbrush? Y N Brand _____

Medical Information and History

Are you in good health? Yes _____ No _____ Don't know _____
Has there been any change in your general health in the last year? Yes _____ No _____
Have you had any serious illness, surgery or been hospitalized in the last 5 years? Yes____ No ____
If yes, describe and give approximate dates _____
_____
_____
Are you currently under the care of a physician (MD or DO) for a specific condition(s)?
Yes____ No ____ If yes, please explain. _____
_____
_____
Date of last physical _____
Name of physician_____ Phone # _____
Address_____

Are you allergic to or have had a reaction to:
latex_____ local anesthetics (Novocain-like drugs) _____ to metals? _____

Please list all medications you are allergic to: _____
_____
_____

Please list all of the prescription medication, over the counter medication, vitamin supplements, herbal supplements and/or diet supplements that you take. Please list the name, the strength and how often you take the medication(s).

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have (or have you had) any of the following, please circle either Y or N.

Y N High Blood Pressure
Y N Heart Disease Type: _____
Y N History of Stroke When? _____
Y N Waking up gasping or choking
Y N Bruxism (grinding) / Clenching
Y N Wears night guard/splint

Y N Mouth breathing in your sleep regularly
Y N Waking with dry mouth
Y N Have frequent headaches or migraines?
Y N Awaken with headache
Y N Feel refreshed when you wake up

Y N Lung disease, please specify: Asthma _____ Tuberculosis _____ emphysema_____
COPD _____ Bronchitis _____ chronic cough_____ other_____
Y N Diabetes Type1-Insulin dependent _____ Type 2 _____ Diet _____
Y N Thyroid disease hypothyroidism (low) _____ hyperthyroidism (high) _____
Y N Gastrointestinal disease ulcer_____ colitis_____ acid reflux (GERD) _____

Y N Do you snore? Occasionally _____ Nightly _____ Soft _____ Loud_____
Y N Suspected Sleep Apnea
Y N Have you been told you stop breathing in your sleep?
Y N Previous Sleep Study when? _____
Y N Sleep Apnea (previously diagnosed) When? _____
Y N Need a CPAP Currently use ____ no longer use CPAP (don't need it ___ won't use it ___)
Y N Use of oral appliance for sleep apnea Type? _____
Y N Had surgery to correct sleep apnea? When/what? _____

Do you have (or have you had) any of the following, please circle either Y or N.

Y N Antibiotics prior to dental work
Y N Rheumatic fever
Y N Rheumatic heart disease
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Pacemaker, when? _____
Y N Damaged heart valves

Y N Congenital heart defects
Y N Heart Surgery, when? _____
Y N Heart Attack, when? _____
Y N Angina
Y N Chest pain on exertion
Y N Heart Stent(s) _____
Y N Other heart problems _____

Y N Joint replacement, which joint(s) and when_____
Y N Artificial Heart Valve Which valve and when? _____

Y N Have you ever had a blood transfusion? When? _____
Y N Organ transplant? When and explain: _____
Y N Diet pills Pondimin_____ Redux_____ Phen-fen_____ Other_____
Y N Liver disease Hepatitis What type? A_____ B_____ C_____ Other specify_____
Y N Autoimmune Disease Lupus_____ Arthritis _____ Rheumatoid arthritis _____
Y N Human Immunovirus (HIV positive status)
Y N Acquired Immune Disease (AIDS)
Y N Human Papilloma Virus (HPV)
Y N Other sexually transmitted disease(s), specify: _____
Y N Cancer/tumors/chemotherapy/radiation treatment _____
Y N Kidney disease, please specify _____
Y N Eating disorder, please specify: _____ Treatment? _____
Y N Seizures or convulsive disorders epilepsy_____ other_____
Y N Neurological disorders If yes, specify _____
Y N Blood disorder, please specify:
Anemia _____ hemophilia _____ sickle cell anemia _____ other_____
Y N Trouble with eyes cataracts_____ glaucoma _____ other _____
Y N Loss of hearing right _____ left_____ Cochlear Implants_____
Y N Tattoos How many _____ Age of oldest tattoo _____
Y N Mental health disorders if yes, specify_____
Y N Consider yourself a nervous person?
Y N Have you ever taken medications for nervousness or depression?
Y N Do you drink alcoholic beverages?
If yes, how much alcohol did you drink in the last 24 hours? _____
In the past week? _____
Y N Have you ever used tobacco? If yes, please check all that apply.
Cigarettes_____ chewing tobacco_____ dip _____ cigar_____ pipe_____
How long have you used tobacco?_____
How much do you use in a day? _____ in a week?
Have you quit? Y N When? _____
Y N Are you alcohol and/or drug dependent? If yes, have you received treatment?
If yes, when and for what _____
Y N Do you or have you ever used drugs or other substances for recreational use?
If yes, please list: _____
_____
Frequency of use (daily, weekly, etc.)_____ How long? _____
Do you currently use recreational drugs? _____

Y N Do you have any disease, condition or concern not listed above? If yes, please specify.
_____
_____

For women only:
Are you or could you be pregnant? Yes ____ No _____
Are you trying to become pregnant at this time? Yes _____ No _____
If pregnant, your expected due date: _____
Name of OB/GYN _____ Phone #_____
Are you nursing? Yes _____ No _____
Are you taking birth control pills or using the birth control patch? Yes _____ No _____
Are you taking hormone replacement therapy? Yes _____ No _____

Epworth Sleepiness Scale

We recognize that sleep apnea is under diagnosed and under treated. Dentists are the front line for screening for sleep apnea. Our goal is to identify possible issues and to protect your overall health. All patients are screened for potential sleep apnea during their oral cancer screening exam. Dr. Corbitt has completed UCLA's mini residency in Sleep Medicine. The Epworth Scale is a screening tool for sleep apnea.

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 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

Sitting and reading……..	0	1	2	3
Watching TV……	0	1	2	3
Sitting inactive in a public place……..	0	1	2	3
As a passenger of a car for an hour without a break……	0	1	2	3
Lying down to rest on the afternoon when circumstances permit...	0	1	2	3
Sitting and talking to someone……..…	0	1	2	3
Sitting quietly after lunch without alcohol……..	0	1	2	3
In a car, while stopped for a few minutes in traffic……. ……	0	1	2	3
Total				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____
Signature of person completing the health history **Date**

If a person other than the patient completed this form, please identify. _____

_____ _____
Signature of person reviewing this form/date **Renee Corbitt, DDS/date**