

# Aspire® Family Dental

"HELPING BRING LOCKPORT INTO THE FUTURE"

5862 Snyder Dr.  
Lockport, NY 14094  
(716) 439-1877

Please fill out all of the sections in **GREEN**. Sections in **BLUE** should be filled out only if it applies to you. You can use the 'arrow' or the 'tab' key to move to the next question or section. If you are online and do not see red outlined boxes below click [HERE](#) to download free **ADOBE READER**.

## Today's Visit

Who may we thank for you referring you to this office? \_\_\_\_\_  
What dental (mouth) related problem (if any) is responsible for your visit today?  
\_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_  
Address (no PO BOX): \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_  
Cellular Phone: \_\_\_\_\_ Sex:  M  F  
Marital Status:  Married  Single  Divorced  Separated  Widowed  
Birth Date (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Would you like to receive information via e-mail:  Y  N Student Status:  Full Time  Part Time  NA  
Employment status:  Full Time  Part Time  Retired  NA  Other \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Responsible Party (If Other Than Above Patient)

Name: \_\_\_\_\_  
Address (no PO BOX): \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_  
Cellular Phone: \_\_\_\_\_ Sex:  M  F  
Marital Status:  Married  Single  Divorced  Separated  Widowed Driver's License #: \_\_\_\_\_  
Birth Date (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Employment status:  Full Time  Part Time  Retired  NA  Other \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am: Policy Holder for the Patient  Y  N  
Primary Policy Holder  Y  N  
Secondary Policy Holder  Y  N

## Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_  
Insured Soc. Sec. #: \_\_\_\_\_ Insured Birth Date (mm/dd/yyyy): \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Employer ID: \_\_\_\_\_ Carrier ID: \_\_\_\_\_

## Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_  
Insured Soc. Sec. #: \_\_\_\_\_ Insured Birth Date (mm/dd/yyyy): \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Employer ID: \_\_\_\_\_ Carrier ID: \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date (mm/dd/yyyy) \_\_\_\_\_

Although our dental team primarily treats the area in and around your mouth, it is IMPORTANT to remember that it is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all of the following questions.

- Are you under a physician's care now?  Yes  No
- Have you ever been hospitalized or had a major operation?  Yes  No
- Have you ever had a serious head or neck injury?  Yes  No
- Are you taking any medications, pills, or drugs?  Yes  No
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Please explain: \_\_\_\_\_  
 Please explain: \_\_\_\_\_  
 Please explain: \_\_\_\_\_  
 Please List: \_\_\_\_\_  
 \*\*\*  
 Please explain: \_\_\_\_\_  
 \*\*\*  
 \*\*\*  
 \*\*\*

**Woman are you:** \_\_\_\_\_  
 Pregnant/Trying to get pregnant? Yes  No  Using contraceptives? Yes  No  Nursing? Yes  No

**Are you allergic to any of the following?**  No Allergies \_\_\_\_\_  
 Aspirin  Sulfa Drugs  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other Please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?**
- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| HIV Positive              | Yes <input type="radio"/> No <input type="radio"/> | Cortisone Medicine        | Yes <input type="radio"/> No <input type="radio"/> | Hemophilia            | Yes <input type="radio"/> No <input type="radio"/> | Radiation Treatments       | Yes <input type="radio"/> No <input type="radio"/> |
| Alzheimer's Disease       | Yes <input type="radio"/> No <input type="radio"/> | Diabetes                  | Yes <input type="radio"/> No <input type="radio"/> | Hepatitis A           | Yes <input type="radio"/> No <input type="radio"/> | Recent Weight Loss         | Yes <input type="radio"/> No <input type="radio"/> |
| Anaphylaxis               | Yes <input type="radio"/> No <input type="radio"/> | Drug Addiction            | Yes <input type="radio"/> No <input type="radio"/> | Hepatitis B or C      | Yes <input type="radio"/> No <input type="radio"/> | Renal Dialysis             | Yes <input type="radio"/> No <input type="radio"/> |
| Anemia                    | Yes <input type="radio"/> No <input type="radio"/> | Easily Winded             | Yes <input type="radio"/> No <input type="radio"/> | Herpes                | Yes <input type="radio"/> No <input type="radio"/> | Rheumatic Fever            | Yes <input type="radio"/> No <input type="radio"/> |
| Angina                    | Yes <input type="radio"/> No <input type="radio"/> | Emphysema                 | Yes <input type="radio"/> No <input type="radio"/> | High Blood Pressure   | Yes <input type="radio"/> No <input type="radio"/> | Rheumatism                 | Yes <input type="radio"/> No <input type="radio"/> |
| Arthritis/Gout            | Yes <input type="radio"/> No <input type="radio"/> | Epilepsy or Seizures      | Yes <input type="radio"/> No <input type="radio"/> | High Cholesterol      | Yes <input type="radio"/> No <input type="radio"/> | Scarlet Fever              | Yes <input type="radio"/> No <input type="radio"/> |
| Artificial Heart Valve    | Yes <input type="radio"/> No <input type="radio"/> | Excessive Bleeding        | Yes <input type="radio"/> No <input type="radio"/> | Hives or Rash         | Yes <input type="radio"/> No <input type="radio"/> | Shingles                   | Yes <input type="radio"/> No <input type="radio"/> |
| Artificial Joint          | Yes <input type="radio"/> No <input type="radio"/> | Excessive Thirst          | Yes <input type="radio"/> No <input type="radio"/> | Hypoglycemia          | Yes <input type="radio"/> No <input type="radio"/> | Sickle Cell Disease        | Yes <input type="radio"/> No <input type="radio"/> |
| Asthma                    | Yes <input type="radio"/> No <input type="radio"/> | Fainting Spells/Dizziness | Yes <input type="radio"/> No <input type="radio"/> | Irregular Heartbeat   | Yes <input type="radio"/> No <input type="radio"/> | Sinus Trouble              | Yes <input type="radio"/> No <input type="radio"/> |
| Blood Disease             | Yes <input type="radio"/> No <input type="radio"/> | Frequent Cough            | Yes <input type="radio"/> No <input type="radio"/> | Kidney Problems       | Yes <input type="radio"/> No <input type="radio"/> | Spina Bifida               | Yes <input type="radio"/> No <input type="radio"/> |
| Blood Transfusion         | Yes <input type="radio"/> No <input type="radio"/> | Frequent Diarrhea         | Yes <input type="radio"/> No <input type="radio"/> | Leukemia              | Yes <input type="radio"/> No <input type="radio"/> | Stomach/Intestinal Disease | Yes <input type="radio"/> No <input type="radio"/> |
| Breathing Problems        | Yes <input type="radio"/> No <input type="radio"/> | Frequent Headaches        | Yes <input type="radio"/> No <input type="radio"/> | Liver Disease         | Yes <input type="radio"/> No <input type="radio"/> | Stroke                     | Yes <input type="radio"/> No <input type="radio"/> |
| Bruise Easily             | Yes <input type="radio"/> No <input type="radio"/> | Genital Herpes            | Yes <input type="radio"/> No <input type="radio"/> | Low Blood Pressure    | Yes <input type="radio"/> No <input type="radio"/> | Swelling of Limbs          | Yes <input type="radio"/> No <input type="radio"/> |
| Cancer                    | Yes <input type="radio"/> No <input type="radio"/> | Glaucoma                  | Yes <input type="radio"/> No <input type="radio"/> | Lung Disease          | Yes <input type="radio"/> No <input type="radio"/> | Thyroid Disease            | Yes <input type="radio"/> No <input type="radio"/> |
| Chemotherapy              | Yes <input type="radio"/> No <input type="radio"/> | Hay Fever                 | Yes <input type="radio"/> No <input type="radio"/> | Mitral Valve Prolapse | Yes <input type="radio"/> No <input type="radio"/> | Tonsillitis                | Yes <input type="radio"/> No <input type="radio"/> |
| Chest Pains               | Yes <input type="radio"/> No <input type="radio"/> | Heart Attack/Failure      | Yes <input type="radio"/> No <input type="radio"/> | Osteoporosis          | Yes <input type="radio"/> No <input type="radio"/> | Tuberculosis               | Yes <input type="radio"/> No <input type="radio"/> |
| Cold Sores/Fever Blisters | Yes <input type="radio"/> No <input type="radio"/> | Heart Murmur              | Yes <input type="radio"/> No <input type="radio"/> | Pain in Jaw Joints    | Yes <input type="radio"/> No <input type="radio"/> | Tumors or Growths          | Yes <input type="radio"/> No <input type="radio"/> |
| Congenital Heart Disorder | Yes <input type="radio"/> No <input type="radio"/> | Heart Pacemaker           | Yes <input type="radio"/> No <input type="radio"/> | Parathyroid Disease   | Yes <input type="radio"/> No <input type="radio"/> | Ulcers                     | Yes <input type="radio"/> No <input type="radio"/> |
| Convulsions               | Yes <input type="radio"/> No <input type="radio"/> | Heart Trouble/Disease     | Yes <input type="radio"/> No <input type="radio"/> | Psychiatric Care      | Yes <input type="radio"/> No <input type="radio"/> | Venereal Disease           | Yes <input type="radio"/> No <input type="radio"/> |
|                           |  |                           |  |                       |  | Yellow Jaundice            | Yes <input type="radio"/> No <input type="radio"/> |

Please list other comments about your health or if you had any other serious illness not listed above:  
 \_\_\_\_\_  
 \_\_\_\_\_

This next section deals with screening information. We have advanced screening and diagnostic equipment for both **Obstructive Sleep Apnea (OSA)** and **Temporomandibular Disorder (TMD)**. As usual, I am making sure our patients have access to what most other dental patients in WNY do not have! Conditions such as **OSA can be life threatening**. We have letters of recommendation from this area's top Sleep Specialists and the associated Sleep Labs because of our dedication and knowledge in this area. OSA affects about 25% of the population. Therefore everyone does not need to be treated. Since this is a medical condition, we can bill your Medical Insurance and NOT take away anything from your current dental benefits. We have already signed up with MANY Medical Insurance companies, including Medicare! Below are basic screening questions that can guide us more to the people who are at risk. Screening forms are NOT perfect! If you think there may be a problem then it is VERY important to mention this to your MD and us!! **TMD** related issues affect many patients by way of jaw pain and discomfort, headaches, premature breaking and wearing of teeth, restorations breaking down much earlier than normal, etc. As you can see, we are taking a whole body approach to your treatment. Please follow the directions on the following page. You are almost done!!!

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date (mm/dd/yyyy) \_\_\_\_\_

**Obstructive Sleep Apnea (OSA)**

**Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations?

	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Watching television -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting in a public place -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
As a passenger in a car for one hour -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Driving a car stopped for a few minutes in traffic -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting and talking to someone -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sitting down quietly after lunch without alcohol -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Lying down to rest in the afternoon -----	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

Please add all checked numbers and write total (if not automatically added): \_\_\_\_\_

**Subjective Sleep Evaluation**

Please highlight either 'Yes' or 'No' from each question

	No (0)	Yes (1)
Do you snore? -----	<input type="radio"/> 0	<input type="radio"/> 1
You or your spouse would consider your snoring louder than a person talking -----	<input type="radio"/> 0	<input type="radio"/> 1
Your snoring occurs almost every night -----	<input type="radio"/> 0	<input type="radio"/> 1
Your snoring is bothersome to your bed partner -----	<input type="radio"/> 0	<input type="radio"/> 1
Do you feel that in some way your sleep is not refreshing or restful? -----	<input type="radio"/> 0	<input type="radio"/> 1
Do you wake up in the morning or at night with headaches? -----	<input type="radio"/> 0	<input type="radio"/> 1
Do you experience fatigue during the day and have difficulty staying awake? -----	<input type="radio"/> 0	<input type="radio"/> 1
Do you have trouble remembering things or paying attention during the day? -----	<input type="radio"/> 0	<input type="radio"/> 1
Do you have high blood pressure? -----	<input type="radio"/> 0	<input type="radio"/> 1

Please add all checked numbers and write total (if not automatically added): \_\_\_\_\_

**Prior Diagnosis**

**Prior Diagnosis**

Have you previously been diagnosed with OSA? -----

If Yes:

When were you diagnosed? (Appox. Month/year) \_\_\_\_\_

Were you put on CPAP Therapy for treatment? \_\_\_\_\_

Are you still using your CPAP every night? \_\_\_\_\_

Please add all checked numbers and write total (if not automatically added): \_\_\_\_\_

**OFFICE USE ONLY**

Advanced screening criteria: If 'yes' to any below, Pt. should be scheduled for advanced OSA screening.

\_\_\_ ESS ≥ 8    \_\_\_ SSE ≥ 3    \_\_\_ PD ≥ 1

**Temporomandibular Disorder (TMD or TMJ)**

Left (L), Right (R), Both (B), None (N)

Head Pain	L	R	B	N	Jaw Pain	L	R	B	N	Jaw Symptoms	L	R	B	N
Front of your head	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Opening your mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Jaw popping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Top of your head	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	While chewing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Jaw clicking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back of your head	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	During the day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Jaw locks open	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Temple area	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	At night time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Jaw locks closed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

Please fill out all of the below information. In order to save you time, we have already placed common responses in many of the spaces below. You do not have to keep these answers. You can freely cross them off and change them! **IF YOU ARE ELECTRONICALLY SUBMITTING THIS FORM YOU CAN SIGN THIS ON THE DAY OF YOUR APPOINTMENT.**

Patient Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

I authorize the office of All Care Family Dental, PLLC dba Aspire® Family Dental to release health information identifying me (including if applicable, information about HIV infection, substance abuse treatment and mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

**ALL**

2. To whom may the information be released name(s) of recipient(s)?

**NAME & RELATIONSHIP TO YOU:**

3. The Purpose(s) for the release (if appropriate, it is acceptable to state “at the request of the individual”)?

**TO OBTAIN REQUIRED INFORMATION**

4. Expiration date or event relating to the individual or purpose for the release:

**NONE**

It is completely your decision whether or not you sign this form. We can't refuse to treat you if you choose not to sign this form.

If you sign this authorization, you can revoke it at a later date. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written statement to the below address telling us your authorization is revoked: All Care Family Dental, PLLC dba Aspire® Family Dental, 5862 Snyder Dr., Lockport, NY 14094

When your authorization is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, State or Federal Law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: \_\_\_\_\_ Print Name: \_\_\_\_\_

Source of Authority: \_\_\_\_\_

**The next page is the last one!!!!!!!!!!!!**

**COMBINED SIGNATURE SECTION – YOU MUST READ, AND SIGN BELOW PRIOR TO TREATMENT**

By signing below you are stating that you understand, acknowledge, agree and will abide by all the parts listed below (PARTS 1-4):

**PART 1**

You have read, understand, and agree to abide by all of the terms, and conditions described in the above mentioned OFFICE POLICIES/CONTRACT (pgs. 3-5). Also, you state the PATIENT REGISTRATION on pg. 8 and MEDICAL HISTORY form located above on pgs. 9-10 was filled out truthfully. I additionally acknowledge receipt of a copy of All Care Family Dental, PLLC dba Aspire® Family Dental NOTICE OF PRIVACY PRACTICES (pg. 6-8) & AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION (pg. 12).

**PART 2**

COLLECTION AGREEMENT: In case of default of payment of the required installments, the whole of the principal sum unpaid at that time shall become immediately due and payable at the option of the holder of this CONTRACT [All Care Family Dental, PLLC dba Aspire® Family Dental]. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts. These costs and/or fees will be added to the principal sum as stated above.

**PART 3**

ASSIGNMENT AND RELEASE: I have reviewed this statement of charges, and hereby authorize payment directly to All Care Family Dental, PLLC dba Aspire® Family Dental of insurance benefits otherwise payable to me. I authorize release of any information relating to this claim. I am responsible for ALL costs of dental related treatment(s) and fee(s).

PATIENT NAME (PRINT): \_\_\_\_\_ DATE (mm/dd/yyyy): \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE (mm/dd/yyyy): \_\_\_\_\_

CONTRACT HOLDER: ALL CARE FAMILY DENTAL, PLLC dba Aspire® Family Dental    DATE: \_\_\_\_\_

**If you are online ONLY!**

-OR-

If you use Microsoft Outlook or Outlook Express, Please click Submit

If you use yahoo, gmail, etc., please click and save this file to your desktop. Send an email to the below address and attach your saved file.  
**Address:** [aspirelockport@aspirefd.com](mailto:aspirelockport@aspirefd.com)

**Any Questions? Please contact us at (716) 439-1877**