Alan Imrek, DDS - First Dental
1730 Williams Trace Blvd, Suite E
Sugar Land, TX 77478 • **Phone:** 281-494-3368

FIRST DENTAL PATIENT APPLICATION

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: ____

ZIP: _____

PHONE: _____ WORK: _____ CELL: _____ OTHER: _____

E-MAIL: _____

BIRTHDATE: _____ MARRIED: ____ SINGLE: ____ OTHER: ____

EMPLOYER: _____ ADDRESS: _____

SPOUSE'S NAME: _____ BIRTHDATE: _____

IN CASE OF EMERGENCY: _____ NUMBER: _____

HOW DID YOU HEAR ABOUT US: _____

DENTAL INSURANCE: _____

RESPONISIBLE FOR ACCOUNT: _____

SUBSCRIBER'S NAME: _____ BIRTHDATE: _____

PATIENT: _____ BIRTHDATE: _____

INSURANCE COMPANY: _____

GROUP #: _____ SOCIAL SECURITY #: _____

I _____ CERTIFY THAT I/DEPENDENT(S) HAVE INSURANCE COVERAGE WITH: _____ ASSIGN DIRECTLY TO DR IMREK ALL INSURANCE BENEFITS, IF ANY. OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF SIGNATURE ON INSURANCE SUBMISSION.

DENTAL HISTORY:

REASON FOR TODAY VISIT: _____ FORMER DENTIST: _____

LAST DENTAL VISIT: _____ LAST DENTAL X-RAY: _____

MOUTH PAIN OR DISCOMFORT: ____ SENSITIVE TEETH: ____ BLEEDING GUMS: ____

GROWTHS: ____ OTHER: ____

DO YOU SNORE: ____ WHAT POSITION (S) DO YOU SLEEP (side back stomach) _____

DO YOU HAVE NOSE CONGESTION: ____ SCALE 1-10 (1 being perfect 10 being worst): ____

HOW RESTED DO YOU FEEL UPON AWAKING IN THE MORNING: ____ DO YOU FLOSS: ____

HOW OFTEN: _____ BRUSH (how many times a day): _____

MEDICAL HISTORY

AIDS/HIV ___
ANEMIA ___
ARTHRITIS ___
ARTIFICIAL JOINTS ___
ASTHMA ___
BACK PROBLEMS ___
BLOOD DISEASE ___
BONE DISEASE ___
CANCER ___
CHEMICAL DEPENDENCY ___
CHEMOTHERAPY ___
CIRCULATORY PROBLEMS ___
CONGENITAL HEART LESIONS ___
CORTISONE TREATMENTS ___
COUGH, PRESISTENT OR BLOODY ___
DIABETES ___
EMPHYSEMA ___
RESPIRATORY DISEASE ___
RHEUMATIC FEVER ___
SCARLET FEVER ___
SHORTNESS OF BREATH ___
SKIN RASH ___
STROKE ___
SWOLLEN FEET/ANKLES ___
SWOLLEN NECK GLANDS ___
THYROID PROBLEMS ___
TONSILITIS ___
TUBERCULOSIS ___
TUMOR/GROWTH HEAD/NECK ___
TUMOR/GROWTH MOUTH ___
ULCERS ___
UNEXPLAINED WEIGHT LOSS ___
VENEREAL DISEASE ___

HAVE YOU EVER TAKEN

Diet medication: FEN-PHEN ___ LONIMIN ___ ADIPEX ___ FASTIN ___ PONDIMIN ___

REDUX ___

Bone medication: FOSAMAX ___ ZOMETA ___ BONIVA ___ ACTONEL ___ OTHER ___

MEDICATION (including vitamins)

ALLERGIES

ASPIRIN ___ BARBITURATES ___CODEINE ___IODINE ___ LATEX ___

LOCAL ANESTHETIC ___ PENICILLIN ___ OTHER ___

I _____ CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY ABILITY.

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FINANCIAL AGREEMENT

Thank you for choosing First Dental for all your dental needs. Although we do accept insurance as a courtesy to our patients, you must understand the following:

- First Dental must have adequate time before your appointment to contact your insurance company to verify coverage.
- First Dental does not participate in any preferred provider plans. If your insurance has a network of providers, First Dental will be considered out-of-network. It is your responsibility to be informed about such matters regarding your own insurance. Please call your insurance for related questions.
- Dental insurance usually pays a percentage up to a set dollar amount.
- Most Dental companies will not tell us the exact dollar amount they will pay. So First Dental must estimate your portions.
- The patient or guardian is ultimately responsible for the full amount of payment for services. This means that is the insurance company rejects or underpays a claim for any reason, the patient or guardian must pay in full for the claim or procedure unpaid or underpaid by insurance.
- If the Explanation of Benefits from your insurance indicates that you overpaid for your visit, any previous credit adjustments made to your account or to your dependent family members account will be removed. After all credit adjustments have been offset you may or may not have a true credit on your account.
- First Dental does not accept secondary insurance.
- If your insurance company mistakenly mails the payment to you, you must bring the check to First Dental because the payment rightfully belongs to us.
- If you do not have dental insurance all charges will be due in full at the time of service rendered.

I understand and agree to the above statement, I accept full responsibility for payment of my (or my dependent's) account balance.

Patient or Guardian Signature: _____

I hereby authorize payment of the dental insurance benefits to be made directly to Alan Imrek, D.D.S. If the insurance company mistakenly mails the payment to me, I will immediately forward and sign the payment over to Alan Imrek, D.D.S.

Patient or Guardian Signature: _____

I authorize release of any information relating to my insurance claim.

Patient or Guardian Signature: _____

FIRST DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____ have received a copy of this office's Notice of Privacy Practices. (Location in the Waiting Area)

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment

Other (Please Specify)

_____

_____

_____

TMJ HEALTH QUESTIONS

Do you get headaches in the temples	**___yes**	**___no**
Do you frequently have neck pain	**___yes**	**___no**
Are your jaw muscles tired when you awake	**___yes**	**___no**
When is pain worse	**___am**	**___pm**
Have you ever had severe blow to the head/jaw	**___yes**	**___no**
Is there family history of TMJ	**___yes**	**___no**
Do you hear ringing, buzzing or hissing in ears	**___yes**	**___no**
Do you feel clicking popping noise in jaw joints	**___yes**	**___no**
Has your jaw ever locked (unable to open or close)	**___yes**	**___no**
Have you ever had a sleep study at a Sleep Clinic	**___yes**	**___no**

GENERA QUESTIONS

How do you feel about the condition and appearance of your smile?

_____
_____
_____

What would you like to improve about your smile?

_____
_____
_____

Do you want to save your stem cells?

_____
_____
_____

Do you have any additional concerns or comments?

_____
_____
_____

First Dental / Dr. Alan Imrek, DDS

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Sleep Screening Questionnaire

Check the below statements that are true.

Patient's Name _____
Phone # _____ Date _____
DOB_____Height_____Weight_____

_____ 1. Sometimes, I stop breathing when I sleep; I may have no memory of this occurring.

_____ 2. I have excessive daytime sleepiness even when I have slept through the night.

_____ 3. I have been diagnosed with depression.

_____ 4. I tend to fall asleep at inappropriate times.

_____ 5. I experience frequent movement ("tossing and turning") while asleep.

_____ 6. I tend to sweat excessively during my sleep.

_____ 7. I often awaken with headaches or a dry mouth.

_____ 8. I am over my ideal weight.

_____ 9. I have high blood pressure.

_____ 10. I have been told that I snore.

Three or more checked statements might indicate symptoms of SLEEP APNEA, a life threatening sleep disorder. A sleep study may be suggested to understand the underlying cause for these symptoms.

The Epworth Sleepiness Scale

Choose the most appropriate number:

0= Would never doze **1**= Slight chance of dozing **2**= Moderate chance of dozing **3**= High chance of dozing

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