MAUREEN R.
LIBBY
DMD
Prosthodontist & Oral Oncologist
Advanced Implant, Restorative & Cosmetic Dentistry
Dental Sleep Medicine

Patient Registration Forms

Patient Information

Name: Last_____First_____MI_____

Preferred Name: _____ **Marital Status:** Single Married Divorced Widowed Minor **Sex:** Male Female

Address: _____ **City, State, Zip:** _____

Telephone #: Work _____ Home_____ Mobile_____

Date of Birth:_____ **Social Security Number**:_____

How did you hear about us?_____

Has any member of your family ever been treated here? Who? _____

Employer:_____ **E-Mail Address:**_____

Dental Insurance Information (Primary)

Insured's Name:_____ **Insured's SSN:**_____ **Insured's Birthday:**_____

Employer:_____ **Position:**_____ **Years Employed**:_____

Dental Insurance Company:_____ **Insurance Co. Address:**_____

Insurance Co. Telephone#:_____ **Group #:** _____ **Plan/Policy #:** _____

Emergency Information

Person to Contact in Case of Emergency:_____

Relationship:_____ **Telephone Number:**_____

Dental History

Purpose of today's visit:_____ **Are you currently in pain?**_____

Your current dental health is: GOOD FAIR POOR **Do you like your smile?** YES NO

Previous/Current Dentist: _____**Last visit date:**_____

Date of most recent dental radiographic (x-rays) exam:_____ **Most recent cleaning:** _____

How many times per day do you brush your teeth? _____ **How often do you floss?**_____

Do you pre-medicate for dental work? YES NO **Do you have difficulty opening or closing your mouth?** YES NO

Have you ever worn a mouth guard / night guard? YES NO **Do you clench or grind your teeth?** YES NO NOT SURE

Is there anything else you would like to discuss with Dr. Libby? _____

_____

Additional Information

Do you breathe mainly through your nose, mouth or both? _____ **Do you have frequent headaches?** YES NO

Do you snore? YES NO **Does anyone in your household snore?** YES NO **Have you ever had a sleep study?** YES NO

Do you feel like you sleep well at night? YES NO **Do you feel excessively sleepy during waking hours?** YES NO

Are you currently being treated for sleep apnea? YES NO **How?** _____

Do you smoke or use tobacco products? YES NO **Have you ever smoked or used tobacco?** YES NO

Do you consume alcoholic beverages? YES NO **How many per week?**_____

Do you drink sodas, carbonated beverages or juices? YES NO **How many per week?** _____

Oral TAP Appliance Patients

Height: _____

Weight: _____

Neck Size: (inches) _____

Medical History

Do you have any current health problems: YES NO **Please explain:**_____ _____

Are you under a Physician's care now? YES NO **Please explain:**_____ _____

Current Physician's Name and Phone Number:_____

Have you been Hospitalized in the last 2 years: YES NO **Please explain:** _____ _____

(Women) Are you pregnant? YES NO **Are you nursing?** YES NO **Are you taking Birth Control Pills:** YES NO

Are you currently taking any medications? YES NO (Please list medications below)

Medication List:

_____
_____

_____

Are you currently or in the past taken Oral or I.V. BISPHOSPHONATES? (Example: FOSAMAX)?
____Yes ____No

Are you currently allergic to any medications? YES NO

Please list any known allergies(ie: medications, food):

_____
_____

_____

Medical History (continued)

Please draw a circle around any of the following which you have had previously or have at present:

Heart Disease/condition	Bruise Easily	Epilepsy or Seizures	Fainting or Dizzy Spells
Heart Attack	Prolonged/Unusual Bleeding	Pacemaker	Anemia
Angina Pectoris	Blood Transfusion	HIV Positive	AIDS
Frequent Chest Pain	Sickle Cell Disease	Cold Sores	Unexplained Weight-loss
High Blood Pressure	Arthritis	Herpes	Sexually Transmitted Disease
Shortness of Breath	Asthma	Psychiatric Treatment	Low blood pressure
Swollen Ankles	Emphysema	Depression	Drug Addiction
Artificial Heart Valve	Tuberculosis(TB)	Cancer	Thyroid Disease
Congenital Heart Disease	Diabetes	Joint replacement	Stroke
Liver Disease	Heart Murmur	Ulcers	Radiation Therapy
Vascular Shunt or Stint	G.I. Tract Problems	Chemotherapy	Rheumatic Fever
Kidney Problems	Dental Implant Prosthesis	Bleeding Disorder	Jaundice
Hepatitis	Cholesterol	Other Implant Prosthesis	GERD or Acid Reflux

Are there any conditions <u>not listed above</u> that you presently have or have had in the past? _____

_____

I acknowledge that all the information I have provided about my medical history and medications is current and correct.

Signature:_____ Date:_____

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Consent for Treatment

I authorize the doctor or designated staff to take x-rays and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I authorize the doctor to perform all recommended treatment, mutually agreed upon by me, and with any needed anesthetics and other materials.

I agree to be responsible for payment in full of all services rendered on my behalf, and on behalf of my dependents. I also understand that such payments are due at the time of service, unless other arrangements have been made in advance.

I understand that the office of Dr. Maureen Libby does not participate with Medicare and cannot file claims to Medicare. Further, I understand that the office of Dr. Maureen Libby is not a preferred provider for any private insurance companies. Our office will assist you in filing dental claims with your insurance company; however, the ultimate responsibility for payment lies with you for the services that you receive. Please note that your insurance is a contract between you, your employer and the insurance company. Our office is not party to that contract; nor can we become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, or usual and customary charges, etc. At your request, we can assist in creating a pre-estimate for the insurance company that may give a more precise estimate of their payments. Please know that insurance companies usually take anywhere from 2-6 weeks to return a pre-estimate.

Patient or Responsible Party Signature:_____**Date:**_____

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Notice of Privacy Practices

I, _____ have received a copy of
(*Please Print Name of Patient or Guardian)*

Dr. Maureen Libby's Notice of Privacy Practices.

Patient or Responsible Party Signature:_____

ALL MEDICAL AND DENTAL RECORDS ARE CONFIDENTIAL

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it was not obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature

_____ Language barriers kept us from obtaining the patient's signature

_____ Other situation:_____