TIME 08:28 AM

City, State, Zip:

Rem. Benefits:

IENT PEGISTRATION

DATE 8/2/2016

		PATIENT RE	GISTRATION		
ID:	Chart ID:				
First Name:		Last Name:			Middle Initial:
Patient Is: Policy Holder	Responsible Party	Preferred Name:			
Responsible Party ( if som	eone other than the patient )-				
First Name:		Last Name:			Middle Initial:
Address:		Addre	ess 2:	2	
City, State, Zip:					Pager:
Home Phone:	Work Phone	e:		Ext:	Cellular:
Birth Date:	Soc Sec	2:		Drive	rs Lic:
Responsible Party is also a Po	blicy Holder for Patient	Primary Insurance	ce Policy Holder		Secondary Insurance Policy Holder
Patient Information —					
Address:		Addre	ss 2:		
City:		State / Zip:			Pager:
Home Phone:	Work Phone	::		Ext:	Cellular:
Sex: Male	Female	Marital Status:	Married Sing	le Divorced	Separated Widowed
Birth Date:	Age	: So	c Sec:	Driver	rs Lic:
E-mail:			I would like to receiv	ve correspondences v	ia e-mail.
	Section 2				Section 3
Employment Full Time Status:	Part Time	Retired			Referred By
Student Status: Full Time	Part Time				tion/Telephone
Medicaid ID:	Pref. De	ntist:		Emer	gency Contact
Employer ID:	Pref. Pharn	nacy:			ncy Contact # referred Times
Carrier ID:	Pref.	Hyg:			referred Phone
Primary Insurance Informa	tion —				
Name of Insured:			Relationship to In	nsured: Self	Spouse Child Other
Insured Soc. Sec:		Insured Birth I	1		
Employer:			Ins. Comp		
Address:			Add		
Address 2:			Addres		
City, State, Zip:			City, State,	Z1p:	
Rem. Benefits:	Rer	n. Deduct:			
Secondary Insurance Infor	mation —		and the second		
Name of Insured:			Relationship to In	nsured: Self	Spouse Child Other
Insured Soc. Sec:		Insured Birth I	Date:		
Employer:	×		Ins. Comp	oany:	
Address:			Add	ress:	
Address 2:			Addres	ss 2:	

City, State, Zip:

Rem. Deduct:

Time 3:08 PM	Time	3:08	PM
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Patient Name:

## New Life Dental Arts Eaglesoft Medical History Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physicia	an's care now?		⊖ Yes ⊖	No	If yes [				
Have you ever been hospitalized or had a major operation?		🔿 Yes 🔿	No	If yes					
Have you ever had a serious head or neck injury?			🗇 Yes 🔿	No	If yes		97 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200 - 200		
Are you taking any medications, pills, or drugs?			🔿 Yes 🖒	No	If yes				
Do you take, or have you			$\odot$ Yes $\odot$	No	If yes				999 gi a waxaa ahaa ahaa isoo isoo isoo isoo iyo iyo ahaa ahaa dadhaa ahaa ah
Have you ever taken Fos			O Yes O		If yes				
any other medications c			0.000		1,00			алан арамалдан тари ардан калан к	
Are you on a special die	t?		🔆 Yes 🔇	No					
Do you use tobacco?			🔿 Yes 🗇	No					
Women: Are you									
Pregnant/Trying to g	et pregnant?			?			Taking or	al contraceptives?	
	p <b>3</b>								
Are you allergic to any of t	the following?							preview	
Aspirin		Penicillin				Codeine		Acrylic	
Metal		Latex				Sulfa Drugs		Local Anesthetics	
Other?					If ves				
Do you use controlled su	ubstances?		⊖ Yes ⊖	No	If yes				
						Same and many and a same and a same and a same a			
Do you have, or have you		1		~ • •		1	25 Mar 26 Ha	I	Mag Ma
AIDS/HIV Positive	🔿 Yes 🔆 No	Cortisone Me	dicine	() Yes		Hemophilia	🔿 Yes 🔿 No	Radiation Treatments	O Yes O No
Alzheimer's Disease	္ Yes ္ No	Diabetes		O Yes		Hepatitis A	🔿 Yes 🔿 No	Recent Weight Loss	Yes No
Anaphylaxis	🔿 Yes 🔿 No	Drug Addictio		O Yes		Hepatitis B or C	O Yes O No	Renal Dialysis	Yes No
Anemia	🔿 Yes 🔿 No	Easily Winde	d	Yes		Herpes	O Yes O No	Rheumatic Fever	🔆 Yes 🖒 No
Angina	ි Yes ි No	Emphysema		O Yes		High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	🔆 Yes 🔆 No	Epilepsy or S	eizures	$\bigcirc$ Yes		High Cholesterol	🔿 Yes 🔿 No	Scarlet Fever	🔆 Yes 🔆 No
Artificial Heart Valve	🔿 Yes 🔿 No	Excessive Ble	-	ି Yes		Hives or Rash	🔿 Yes 🔿 No	Shingles	် Yes ် No
Artificial Joint	🔿 Yes 🔿 No	Excessive Th		$\bigcirc$ Yes		Hypoglycemia	🔿 Yes 🔿 No	Sickle Cell Disease	🔆 Yes 🔆 No
Asthma	🔿 Yes 🔿 No	Fainting Spell	s/Dizziness	Yes		Irregular Heartbeat	🔿 Yes 🔿 No	Sinus Trouble	🔆 Yes 🔆 No
Blood Disease	ြ Yes ြ No	Frequent Co	ugh	Yes		Kidney Problems	🔿 Yes 🔿 No	Spina Bifida	O Yes O No
Blood Transfusion	🔿 Yes 🔿 No	Frequent Dia	rrhea	Yes		Leukemia	🔿 Yes 🔆 No	Stomach/Intestinal Disease	🔿 Yes 🗍 No
Breathing Problems	🔿 Yes 🔿 No	Frequent Hea	adaches	Yes	-	Liver Disease	Yes O No	Stroke	🔆 Yes 🔆 No
Bruise Easily	🔿 Yes 🔿 No	Genital Herpe	es	Yes	O No	Low Blood Pressure	🔿 Yes 🔿 No	Swelling of Limbs	🔿 Yes 🔿 No
Cancer	💮 Yes 🔿 No	Glaucoma		🔿 Yes	🔿 No	Lung Disease	🔿 Yes 🔿 No	Thyroid Disease	Yes No
Chemotherapy	🔿 Yes 🔿 No	Hay Fever		🔿 Yes	$\bigcirc$ No	Mitral Valve Prolapse	🗇 Yes 🔾 No	Tonsillitis	$\bigcirc$ Yes $\bigcirc$ No
Chest Pains	🔿 Yes 🔿 No	Heart Attack	/Failure	Yes	No	Osteoporosis	🔿 Yes 💮 No	Tuberculosis	🔿 Yes 🔿 No
Cold Sores/Fever Blister	s 🔿 Yes 🔿 No	Heart Murmu	ır	ි Yes	🔿 No	Pain in Jaw Joints	🔆 Yes 🔆 No	Tumors or Growths	🔆 Yes 🔿 No
Congenital Heart Disorder	🔿 Yes 🔿 No	Heart Pacem	aker	💮 Yes	🔿 No	Parathyroid Disease	🔿 Yes 💮 No	Ulcers	🔿 Yes 🔿 No
Convulsions	🔿 Yes 🔿 No	Heart Troubl	e/Disease	🔿 Yes	🔿 No	Psychiatric Care	🔿 Yes 🔿 No	Venereal Disease	🔿 Yes 🔿 No
								Yellow Jaundice	🔿 Yes 🔆 No
Have you ever had any	serious illness n	ot listed	🔿 Yes 🔇	No	If yes			1	
Comments:									
		ar na a Mhair Marainn a chuir ann ann ann ann ann ann ann ann ann an	1949-19-19-19-19-19-19-19-19-19-19-19-19-19		1997 (m. 1992), (b. 17) (m. 1997), (b. 1997) (b. 1997), (b. 1997)		*****	an a	an a

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

## **Sleep Screening Questionnaire**

Please answer the questions below to help us assess the possibility of a sleep disorder. There is often a correlation between TMJ disorders and sleep disorders. Sleep apnea can increase your risk for many health conditions.

Epworth Sleepiness Scale         How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?         0 = I would never doze       2 = I have a moderate chance of dozing         1 = I have a slight chance of dozing       3 = I have a high chance of dozing         3. Sitting and reading       Chance of Dozing         2. Watching TV	Patien	t Name:	Height:We	eight:					
U = I would never doze       2 = I have a moderate chance of dozing         1 = I have a slight chance of dozing       3 = I have a high chance of dozing         Sitting and reading       Chance of Dozing         1. Sitting and reading	Epwoi	th Sleepiness Scale							
U = I would never doze       2 = I have a moderate chance of dozing         1 = I have a slight chance of dozing       3 = I have a high chance of dozing         Sitting and reading       Chance of Dozing         1. Sitting and reading	How li	kely are you to doze off or fall asleep in the	following situations, in contrast to ju	ist feeling	tired?				
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Situation       Chance of Dozing         1. Sitting and reading		1 = I have a slight chance of dozing							
1. Sitting and reading         2. Watching TV         3. Sitting inactive in a public place (e.g. a theatre or a meeting)         4. As a passenger in a car for an hour without a break         5. Lying down to rest in the afternoon when circumstances permit         6. Sitting quietly after lunch without alcohol         7. Sitting quietly after lunch without alcohol         8. In a car while stopped for a few minutes in traffic         Total Score         Yes No Not Sure         1. Have you been told (or noticed on your own) that you snore most nights?         2. Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep, sometimes followed by a GASP?         3. Are you tried, fatigued or sleepy on most days?         4. Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?         5. Are you overweight?         6. Have you ever been diagnosed with obstructive sleep apnea (OSA)?         7. Are you aware of family history of OSA?         8. Are you aware of clenching or grinding your teeth at night?         10. Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?         11. Do you often feel tired, fatigued or sleepy during the daytime?         12. Has anyone observed you stop breathing your sleep?         13. Do you have, or are you being treated for high blood pressure? <td>Situati</td> <td colspan="8">Situation Chance of Dozing</td>	Situati	Situation Chance of Dozing							
<ul> <li>3. Sitting inactive in a public place (e.g. a theatre or a meeting)</li> <li>4. As a passenger in a car for an hour without a break</li> <li>5. Lying down to rest in the afternoon when circumstances permit</li> <li>6. Sitting and talking to someone</li> <li>7. Sitting quietly after lunch without alcohol</li> <li>8. In a car while stopped for a few minutes in traffic</li> <li>Total Score</li> <li>Yes No Not Sure</li> <li>1. Have you been told (or noticed on your own) that you snore most nights?</li> <li>2. Have you been told (or noticed on your own) that you stop breathing or struggle</li> <li>to breathe in your sleep, sometimes followed by a GASP?</li> <li>3. Are you tired, fatigued or sleepy on most days?</li> <li>4. Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?</li> <li>5. Are you overweight?</li> <li>6. Have you ever been diagnosed with obstructive sleep apnea (OSA)?</li> <li>9. Are you aware of family history of OSA?</li> <li>9. Are you aware of clenching or grinding your teeth at night?</li> <li>10. Do you onter feel tired, fatigued or sleepy during the daytime?</li> <li>11. Do you ooften feel tired, fatigued or sleepy during the daytime?</li> <li>12. Has anyone observed you stop breathing during your sleep?</li> <li>13. Do you have, or are you being treated for high blood pressure?</li> <li>14. Are you S0 years old or older?</li> <li>15. Does your neck measure more than 15 ½ inches (40cm) around?</li> <li>16. Are you a male?</li> </ul>		- 0		0					
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to breathe in your sleep, sometimes followed by a GASP?       I       I       I         3.       Are you tired, fatigued or sleepy on most days?       I       I       I         4.       Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?       I       I       I         5.       Are you overweight?       I       I       I       I         6.       Have you ever been diagnosed with obstructive sleep apnea (OSA)?       I       I       I         7.       Are you aware of family history of OSA?       I       I       I       I         9.       Are you aware of clenching or grinding your teeth at night?       I       I       I       I         10.       Do you often feel tired, fatigued or sleepy during the daytime?       I       I       I       I         11.       Do you observed you stop breathing during your sleep?       I       I       I       I         12.       Has anyone observed you stop breathing during your sleep?       I       I       I       I         13.       Do you have, or are you being treated for high blood pressure?       I       I       I       I         14.       Are you 50 years old or older?       I       I       I       I       I <td>2.</td> <td>Have you been told (or noticed on your o</td> <td>wn) that you stop breathing or strug</td> <td>gle –</td> <td></td> <td></td>	2.	Have you been told (or noticed on your o	wn) that you stop breathing or strug	gle –					
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control either of these conditions)?       I       I       I         5.       Are you overweight?       I       I       I         6.       Have you ever been diagnosed with obstructive sleep apnea (OSA)?       I       I       I         7.       Are you aware of family history of OSA?       I       I       I       I         8.       Are you aware of clenching or grinding your teeth at night?       I       I       I       I         9.       Are you aware of clenching or grinding your teeth at night?       I       I       I       I         10.       Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?       I       I       I       I         11.       Do you often feel tired, fatigued or sleepy during the daytime?       I       I       I       I         12.       Has anyone observed you stop breathing during your sleep?       I       I       I       I         13.       Do you have, or are you being treated for high blood pressure?       I       I       I       I         14.       Are you 50 years old or older?       I       I       I       I       I         15.       Does your neck measure more than 15 ½ inches (40cm) around?       I       I       I       I									
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7.       Are you currently being treated for OSA?       □       □       □         8.       Are you aware of family history of OSA?       □       □       □         9.       Are you aware of clenching or grinding your teeth at night?       □       □       □         10.       Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?       □       □       □         11.       Do you often feel tired, fatigued or sleepy during the daytime?       □       □       □         12.       Has anyone observed you stop breathing during your sleep?       □       □       □         13.       Do you snore loud or older?       □       □       □         14.       Are you 50 years old or older?       □       □       □         15.       Does your neck measure more than 15 ¼ inches (40cm) around?       □       □       □         16.       Are you a male?       □       □       □       □									
8.       Are you aware of family history of OSA?       Image: Comparison of the start			uctive sleep apnea (OSA)?						
9.       Are you aware of clenching or grinding your teeth at night?       □       □       □         10.       Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?       □									
10.       Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?       Image: Closed door)         11.       Do you often feel tired, fatigued or sleepy during the daytime?       Image: Closed door)         12.       Has anyone observed you stop breathing during your sleep?       Image: Closed door)         13.       Do you have, or are you being treated for high blood pressure?       Image: Closed door)         14.       Are you 50 years old or older?       Image: Closed door)         15.       Does your neck measure more than 15 ½ inches (40cm) around?       Image: Closed door)         16.       Are you a male?       Image: Closed door)									
closed door)?       L       L       L         11. Do you often feel tired, fatigued or sleepy during the daytime?       L       L       L         12. Has anyone observed you stop breathing during your sleep?       L       L       L         13. Do you have, or are you being treated for high blood pressure?       L       L       L         14. Are you 50 years old or older?       L       L       L         15. Does your neck measure more than 15 ½ inches (40cm) around?       L       L       L         16. Are you a male?       L       L       L       L									
12. Has anyone observed you stop breathing during your sleep?       IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		closed door)?							
13. Do you have, or are you being treated for high blood pressure?       Image: Constraint of the second seco	11.	Do you often feel tired, fatigued or sleepy	during the daytime?						
14. Are you 50 years old or older?     Image: Constraint of the second sec	12.	Has anyone observed you stop breathing	during your sleep?						
15. Does your neck measure more than 15 ½ inches (40cm) around?       I       I       I         16. Are you a male?       I       I       I	13.		high blood pressure?						
16. Are you a male?	14.								
	15.	Does your neck measure more than 15 ¾ i	nches (40cm) around?						
17. Do you weigh more for your height than is shown in the table below?	16.								
	17.	Do you weigh more for your height than is	shown in the table below?						

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4'10"	167	5'3"	197	5'8"	230	6'1"	265
4'11"	173	5'4"	204	5'9"	237	6'2"	272
5′	179	5'5"	210	5'10"	243	6'3"	279
5'1"	185	5'6"	216	5'11"	250	6'4"	287
5'2″	191	5'7"	223	6'	258	6'5"	295
	Weights show	n in the ta	bles above corr	respond to	BMI of 35 for a	given heigi	ht.

New Life Dental Arts | Dr. Amy Moslander-Thompson 425.397.8888 | www.NewLifeDentalArts.com





Date:
То:
Fax:
Fr:
Ph: (425) 397-8888
Fax: (425) 397-8889
Patient: DOB:
Records Requested: Please email or mail a current copy of patient's Pano, BWs, FMX
and Perio Charting. Thank you.
Mailing Address:
Attn: Dr. Amy Moslander-Thompson, DDS
New Life Dental Arts
9633 Market Place Suite 202
Lake Stevens, WA 98258
OR

Please email requested records to: office@newlifedentalarts.com

We would like to thank you in advance for your prompt attention. Have a wonderful day!

Patient/Guardian Signature

Date

If you have received this fax in error, please contact our office and let us know as soon as possible. Due to HIPAA, please return the fax or shred immediately. Thank you.

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