Front Range Dental Sleep Medicine, PC

Dennis R. Bailey, DDS – Andrew T. Smith, DDS

General Dentists: Practice Restricted to
Intraoral Appliance Therapy for Sleep Apnea & Snoring
Orofacial Pain , Temporomandibular Joint Disorders (TMJ) & Related Headaches
Orthodontics

PATIENT REGISTRATION & INFORMATION

Name_____ Date_____

Street Address_____

City_____ State_____ Zip Code_____

Phone - Home _____Work _____ Cell _____

Occupation_____

Social Security Number_____Birthdate_____Age_____

Marital Status_____ Name of spouse_____

Purpose of Visit_____

Chief / Main Concern _____

Whom may we thank for referring you to this office? _____

Address: _____ Phone # _____

Emergency Contact_____ Phone #_____ Relationship_____

INSURANCE INFORMATION

Insurance Company_____ ID Number_____

Group/Policy Number_____ Insured's SSN_____

Insurance Address_____ Phone _____

Insured's Name_____ Their Date of Birth _____

HEALTH HISTORY

__Anemia __Diabetes __Epilepsy/Seizure __Bleeding Disorder __Mitral Valve Prolapse

__Heart Disease __Artificial Heart Valves __Congenital Heart Defect __Heart Murmur

__History of Rheumatic Fever/ Endocarditis __Heart Surgery __Pacemaker __ A-fib

__High Blood Pressure __Allergy to latex __Tuberculosis __Kidney Disease

__Prosthetic Joint (knee, hip, or other joint) __Hepatitis/Liver Disease __Infectious Disease (HIV or AIDS)

__Asthma or other Breathing Disorder __Acid Reflux

__*Other Health Issues* _____

__Allergy: _____

Are there any other health problems of importance? _____

Continue on Back ➔

Are you taking medication? __ No __ Yes (If so please complete the Medication List)

Are there any physical conditions we need to know about? _____

For women: Are you pregnant? __No __Yes, Are you taking birth control medication? __No __Yes, Name: _____

Name of your Primary Care Physician_____Phone_____

Location_____

Please list the names of any Doctors you are currently seeing or see on a regular basis:

Name	Phone Number	Reason or condition being treated
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIFESTYLE AND PHYSICAL ACTIVITIES
(Please check the appropriate response)

Do you use Tobacco? __No __Yes Type: __Cigarettes __Packs per day __Cigars __Smokeless

Drink alcohol-containing beverages? __No __Yes Type consumed __Beer __Wine __Liquor
__Drinks per week

Engage in high risk activities (please describe):_____

Exercise: __No __Yes Please Describe:_____

Do you have a lot of stress in your life? __No __Yes

AUTHORIZATION FOR INITIAL VISIT

I understand that the visit scheduled upon completion of this document is for an evaluation and consultation. The visit will consist of a review of my history and any reports that are available and clinical examination followed by a consultation and discussion of the findings and he recommended course of treatment/action.

Signature:_____

AUTHORIZATION TO SUBMIT INSURANCE CLAIM

I authorize Dr. Bailey to submit claims on my behalf for payment of services rendered to the named insurance company on this form. Furthermore, I authorize the insurance company to pay benefits directly to Dr. Bailey on my behalf. I understand that if the insurance company denies payment of the claims, or if payment is directly mailed to me, I become responsible for the payment of the services rendered by Dr. Bailey. After 90 days I accept full responsibility for payment to Dr. Bailey.

Signature:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Bailey to release information relative to my medical history, diagnosis and treatment to the named insurance company or to any health care provider related to my treatment.
Signature:_____

I verify that all of the information is accurate and correct and all health / medical conditions and medications have been disclosed.
Signature: _____