



The safety of our employees, patients, and community remain Smart Smile Dental's overriding priority. As the coronavirus disease 2019 (COVID-19) outbreak continues to evolve and spreads globally, Smart Smile Dental is monitoring the situation closely and will periodically update company guidance based on current recommendations from the Centers for Disease Control and Prevention and the California Dental Association.

ARE YOU AT RISK?	
1. Have you traveled out-of-state or internationally within the last month?	YES NO
2. Have you experienced any cold or flu-like symptoms such as: fever, coughing, or shortness of breath within the last 14 days?	YES NO
3. Have you come into contact with someone confirmed to have COVID-19?	YES NO
4. Have you been in close contact with anyone who has traveled within the last 30 days internationally?	YES NO
5. Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES NO
6. Have you experienced recent loss of taste or smell?	YES NO

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

Signature \_\_\_\_\_ Date: \_\_\_\_\_

# SMART SMILE DENTAL

Dr. Lori Bagai DDS Inc

## FINANCIAL OPTIONS

*Our commitment is to provide quality comprehensive dental care to the entire family through exceptional service and utilization of advanced technology.*

### METHODS OF PAYMENT

Cash, check or credit card, Dental Insurance, CareCredit

### DENTAL INSURANCE

1. We are pleased that you have dental insurance and our office will assist you in obtaining the maximum benefit specified in your contract. **Your insurance contract is between you, your employer and the insurance company.** You are responsible for all payments due.
2. As a courtesy to you we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization. We will wait 30 days for insurance payment, after 30 days you are responsible for the payment that is expected from the insurance. **Once we receive the Explanation of Benefits from the insurance, adjustments will be made and your account reconciled.**
3. **We ask that your estimated co-payment and deductible be paid at the time of scheduling the appointment.**
4. Some insurance companies deny coverage because in their opinion the treatment was not needed. We use our clinical judgement and training in diagnosing according to standard of care. **If services are rendered and insurance denies payment for any reason, payment is due in full as soon as the claim processes.**

### RELATED INFORMATION

1. **In the event that the account is not paid and we refer the account to collection, you will be responsible for all of the fees incurred in the collection of your bill (i.e. attorney fees, court costs and collection agency fees).**
2. Your appointment time and chair has been reserved exclusively for you. Any change in your appointment affects many patients, 48 hours advanced notice is needed to avoid a \$75 charge. If you have a 2 hour or longer appointment, the fee will be \$150.
  - CANCELLATIONS: To avoid a cancellation fee you must cancel appointment 48 hours in advance. **48 hours is defined as two business days. Messages left over the weekend are not considered sufficient notice.** \*NO Email/Text/Online CANCELLATIONS\*

**Who may we thank for referring you?**

☐ Online Word Search \_\_\_\_\_ ☐ Insurance \_\_\_\_\_ ☐ Friend/Patient \_\_\_\_\_

*I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from the services rendered. I agree to be responsible for any charges not paid by my dental plan.*

**Patients NAME:** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# Health History Form



American Dental Association  
www.ada.org

E-mail:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
<div>LastFirstMiddle</div>			( )		( )	
Address:			City:		State: Zip:	
<div>Mailing address</div>						
Occupation:			Height: Weight:		Date of birth: Sex: M F	
SS# or Patient ID:			Emergency Contact:		Relationship:	
			( )		( )	
					<i>Include area codes</i>	
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
<b>Do you have any of the following diseases or problems:</b> <span style="float: right;"><b>(Check DK if you Don't Know the answer to the question)</b></span>						
Active Tuberculosis..... <span style="float: right;">Yes No DK</span>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
Persistent cough greater than a 3 week duration..... <span style="float: right;"><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></span>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
Cough that produces blood..... <span style="float: right;"><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></span>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
Been exposed to anyone with tuberculosis..... <span style="float: right;"><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></span>						
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>						
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>						

## Dental Information For the following questions, please mark (X) your responses to the following questions.

<b>Yes No DK</b>			<b>Yes No DK</b>		
Do your gums bleed when you brush or floss? .....			Do you have earaches or neck pains? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Are your teeth sensitive to cold, hot, sweets or pressure? .....			Do you have any clicking, popping or discomfort in the jaw? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Does food or floss catch between your teeth? .....			Do you brux or grind your teeth? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Is your mouth dry? .....			Do you have sores or ulcers in your mouth? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Have you had any periodontal (gum) treatments? .....			Do you wear dentures or partials? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Have you ever had orthodontic (braces) treatment? .....			Do you participate in active recreational activities? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Have you had any problems associated with previous dental treatment? .....			Have you ever had a serious injury to your head or mouth? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Is your home water supply fluoridated? .....			Date of your last dental exam:		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			What was done at that time?		
Do you drink bottled or filtered water? .....					
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>					
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			Date of last dental x-rays:		
Are you currently experiencing dental pain or discomfort? .....			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>					
What is the reason for your dental visit today?					
How do you feel about your smile?					

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<b>Yes No DK</b>			<b>Yes No DK</b>		
Are you now under the care of a physician? .....			Have you had a serious illness, operation or been hospitalized in the past 5 years? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Physician Name: Phone: <i>Include area code</i>			If yes, what was the illness or problem?		
<div>( )</div>					
Address/City/State/Zip:					
Are you in good health? .....			Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Has there been any change in your general health within the past year? .....			If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:		
<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
If yes, what condition is being treated?			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
Date of last physical exam:			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		
			<div><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></div>		

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes No DK</b>
Do you wear contact lenses? .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date: ..... If yes, have you had any complications? .....			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date Treatment began: .....			
<b>Allergies</b> - Are you allergic to or have you had a reaction to: <b>Yes No DK</b> To all <b>yes</b> responses, specify type of reaction.			<b>Yes No DK</b>
Local anesthetics .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Metals .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Latex (rubber) .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Iodine .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hay fever/seasonal .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Animals .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Food .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>			
<b>Yes No DK</b>			<b>Yes No DK</b>
Artificial (prosthetic) heart valve .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired CHD with residual defects .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>			
<b>Yes No DK</b>			<b>Yes No DK</b>
Cardiovascular disease: .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart murmur .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart defects .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mitral valve prolapse .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pacemaker .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Abnormal bleeding .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Anemia .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Blood transfusion .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, date: .....			
Hemophilia .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
AIDS or HIV infection .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arthritis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Autoimmune disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatoid arthritis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Systemic lupus erythematosus .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bronchitis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Emphysema .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sinus trouble .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cancer/Chemotherapy/ Radiation Treatment .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Chest pain upon exertion .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Chronic pain .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Diabetes Type I or II .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Eating disorder .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Malnutrition .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Gastrointestinal disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
G.E. Reflux/persistent heartburn .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ulcers .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thyroid problems .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Stroke .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Glaucoma .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hepatitis, jaundice or liver disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Epilepsy .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Fainting spells or seizures .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Neurological disorders .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, specify: .....			
Sleep disorder .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mental health disorders .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Specify: .....			
Recurrent Infections .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Type of infection: .....			
Kidney problems .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Night sweats .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Osteoporosis .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent swollen glands in neck .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Severe headaches/ migraines .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Severe or rapid weight loss .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sexually transmitted disease .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Excessive urination .....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....			
Name of physician or dentist making recommendation:			Phone:
Do you have any disease, condition, or problem not listed above that you think I should know about? .....			
Please explain:			

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

## FOR COMPLETION BY DENTIST

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Review of System (ROS)

Have you ever had, or do you now have any of the conditions listed?

### I. Skin \_\_\_\_\_

Itching \_\_\_\_\_

Rash \_\_\_\_\_

Ulcers \_\_\_\_\_

Pigmentations \_\_\_\_\_

Lack of loss of body hair \_\_\_\_\_

### II. Eyes \_\_\_\_\_

Blurring of vision \_\_\_\_\_

Double vision \_\_\_\_\_

Drooping of \_\_\_\_\_

eyelids \_\_\_\_\_

Glaucoma \_\_\_\_\_

### III. Extremities \_\_\_\_\_

Varicose veins \_\_\_\_\_

Swollen, painful joints \_\_\_\_\_

Muscles weakness, pain \_\_\_\_\_

Bone deformity, fracture \_\_\_\_\_

Prosthetic joints \_\_\_\_\_

### IV. Ear, Nose, Throat \_\_\_\_\_

Earache \_\_\_\_\_

Hearing loss \_\_\_\_\_

Frequent nosebleeds \_\_\_\_\_

Hoarseness \_\_\_\_\_

### V. Respiratory \_\_\_\_\_

Cough, blood in sputum \_\_\_\_\_

Emphysema, bronchitis \_\_\_\_\_

Wheezing, asthma \_\_\_\_\_

Tuberculosis, exposure to \_\_\_\_\_

### VI. Cardiac \_\_\_\_\_

Shortness of breath \_\_\_\_\_

Pain, pressure in chest \_\_\_\_\_

Swelling of ankles \_\_\_\_\_

High, low blood pressure \_\_\_\_\_

Rheumatic, scarlet fever \_\_\_\_\_

Heart murmur, attack \_\_\_\_\_

Prosthetic valves/pacemakers \_\_\_\_\_

### VII. Gastrointestinal \_\_\_\_\_

Difficulty swallowing \_\_\_\_\_

Abdominal pain, ulcers \_\_\_\_\_

Hepatitis, jaundice \_\_\_\_\_

Liver disease \_\_\_\_\_

### VIII. Genitourinary \_\_\_\_\_

Difficulty, pain on urination \_\_\_\_\_

Blood in urine \_\_\_\_\_

Excessive urination \_\_\_\_\_

Kidney infections \_\_\_\_\_

Sexually transmitted disease \_\_\_\_\_

### IX. Endocrine \_\_\_\_\_

Thyroid trouble \_\_\_\_\_

Weight change \_\_\_\_\_

Diabetes \_\_\_\_\_

Excessive thirst \_\_\_\_\_

### X. Hematopoietic \_\_\_\_\_

Easy bruising, excessive bleeding \_\_\_\_\_

Persistent lymphadenopathy \_\_\_\_\_

G6PD deficiency \_\_\_\_\_

Anemia \_\_\_\_\_

HIV infection, AIDS \_\_\_\_\_

Leukemia, problems with immune system \_\_\_\_\_

Spleen problems \_\_\_\_\_

### XI. Neurologic \_\_\_\_\_

Frequent headaches \_\_\_\_\_

Dizziness, fainting \_\_\_\_\_

Epilepsy fits \_\_\_\_\_

Neuritis, neuralgia \_\_\_\_\_

Paresthesia, numbness \_\_\_\_\_

Paralysis \_\_\_\_\_

### XII. Psychiatric \_\_\_\_\_

Nervousness \_\_\_\_\_

Irritability \_\_\_\_\_

Depression, excessive worry \_\_\_\_\_

Nervous breakdown \_\_\_\_\_

### XIII. Growth Of Tumor \_\_\_\_\_

Radiotherapy/chemotherapy \_\_\_\_\_

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

Date: \_\_\_\_\_

## Epworth Sleepiness Scale Questionnaire

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

1. Have you ever been told you stop breathing while asleep?	Y / N	8
2. Have you ever fallen asleep or nodded off while driving?	Y / N	6
3. Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y / N	6
4. Do you feel excessively sleep during the day?	Y / N	4
5. Do you snore, or have you ever been told that you snore?	Y / N	4
6. Do you have trouble falling asleep?	Y / N	4
7. Do you have trouble staying asleep once you fall asleep?	Y / N	4
8. Do you kick or jerk your legs while sleeping?	Y / N	3
9. Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y / N	3
10. Do you wake up with headaches during the night or in the morning?	Y / N	3
11. Have you had weight gain and found it difficult to lose?	Y / N	2
12. Have you taken medication for, or been diagnosed with high blood pressure?	Y / N	2
Total Score		

### For Doctor/Staff Use Only

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

#### Visual Indications

- ☐ Enlarged/Scalloped Tongue
- ☐ Retruded Lower Jaw
- ☐ High Arching Hard Palate
- ☐ Bruxism
- ☐ Gastroesophageal Reflux
- ☐ Enlarged Tonsils
- ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? Yes or No

Are you currently using a CPAP machine? Yes or No (if yes) Do you use it every night? Yes or No

Notes:

Patient name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date: \_\_\_\_\_

# Adjunctive Oral Abnormalities Screening Form

Complete each time the exam is offered and place in the patient's file

This practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral abnormalities and their relationship with serious diseases such as oral cancer, and we do offer screenings for these warning signs to every patient.

Oral cancer is one of the deadliest diseases we encounter, and research shows that the late detection of oral cancer is the primary reason that mortality rates are so high<sup>1</sup>. As is the case with most other cancers, age is a primary risk factor for oral cancer. Tobacco use is also a major predisposing risk factor, however 1 in 4 who are diagnosed with oral cancer have no known risk factors.\*

We find that using ViziLite TBlue - along with a visual examination - improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of abnormalities can minimize or eliminate the harmful and potentially disfiguring effects of serious oral diseases such as cancer and possibly save your life<sup>1</sup>. A painless exam gives us a better chance of finding any oral abnormalities you may have at an early stage. In our practice, the exam will be offered to you annually.

Dental insurance may or may not cover the exam. However, our office is happy to verify your coverage for you. We will also provide you with a medical insurance form to use to file this procedure with your medical insurance provider. The fee for this exam is \$ 65

## ViziLite<sup>®</sup> TBlue<sup>®</sup>

*because early detection may save lives.*

**\*Oral cancer risks include:**

- Tobacco use
- Chronic alcohol consumption
- Oral HPV 16/18 infection

**25% of oral cancers occur  
in people who don't smoke  
and have no other risk factors**

☐ **Yes.** I authorize the clinician to perform the ViziLite TBlue exam along with the standard oral cancer examination. I accept financial responsibility for this exam.

☐ **No.** I would prefer not to have an oral abnormality screening exam at this time.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**dm** 1-800-4DenMat  
(1-800-433-6628)  
**DenMat<sup>®</sup>** [www.denmat.com](http://www.denmat.com)

# Medical Records Release Form

By signing this form, I authorize my health care provider/hospital \_\_\_\_\_ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the dental provider listed below.

Patient Full Name (Print Last Name, Middle, First): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The information you may release subject to this signed medical release form is as follows:

- ☒ Entire Medical Record (2 years)
- ☐ Medication Record
- ☐ Hospital Reports
- ☐ Radiology Reports
- ☐ Personal Health Profile
- ☐ Progress Notes

Release my protected health information to the following physician/facility and/or those directly associated in my medical are:

Name: Dr. Lori Bagai / Smart Smile Dental

Address: 1110 E Chapman Ave. Suite 105 Orange, CA 92866

- ☒ Mail to Address Listed Above: 1110 E Chapman Ave. Suite 105 Orange, CA 92866
- ☐ Fax Number/Attention: 714-744-8102 / ATTN: Maeghan

The purpose/reason for this release of information is as follows: Optimize dental care.

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Signature of Patient/Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

# SIGNATURE RELEASE STATEMENT

## YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS;
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to **Dr. Lori Bagai / Smart Smile Dental**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature \_\_\_\_\_

Patient Full Name (printed) \_\_\_\_\_

Parent Signature (if minor) \_\_\_\_\_

Witness \_\_\_\_\_

Date Signed \_\_\_\_\_

COMPARISONS *OF* DIRECT/INDIRECT RESTORATIVE DENTAL MATERIALS  
ACKNOWLEDGEMENT AND HIPAA ACKNOWLEDGEMENT

COMPARISONS OF DIRECT/INDIRECT RESTORATIVE  
**DENTAL MATERIALS ACKNOWLEDGEMENT**

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I have received the Notice of Comparisons of Direct/Indirect Restorative Dental Materials, and I have been provided an opportunity to review them.

Name  Birthdate

Signature  Date

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**NOTICE OF PRIVACY PRACTICES HIPAA**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY  
SIGN BELOW THAT YOU HAVE RECEIVED THIS INFORMATION.

Name

Signature  Date