Welcome To Our Practice!

BAYAREA Sleep Apnea Oral Appliance Center

Please fill out both sides of this form

MILLBRAE DENTAL CARE SHERRY TSAI, DDS

Referred by: _____ **Date**: _____

About You

□Mr. □Mrs. □Ms □Dr.

Name: (First)_____ (Last)_____ **Nickname**:_____

Phone: Cell: _____ Home:_____ Work:_____ Other:_____

Address: _____ City: _____ State: _____ Zip: _____

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

E-Mail: _____

Employer/Student: _____ **Occupation/Major**:_____

Spouse/Partner Information

Name: (First)_____ (Last)_____ □Mr. □Mrs. □Ms □Dr.

Phone: Cell: _____ Home:_____ Work:_____

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

Employer: _____

Primary Insurance Coverage

Insurance Co. Name:_____ Insurance Co. Phone#:_____

Group # (Plan, Local or Policy#): _____ **Insured's Employer**: _____

Insured's Date of Birth: _____ **Insured's Insurance ID or SS#**: _____

Insured's Name: _____ **Relationship to You**: _____

Secondary Insurance

Insurance Co. Name:_____ Insurance Co. Phone#:_____

Group # (Plan, Local or Policy#): _____ **Insured's Employer**: _____

Insured's Date of Birth: _____ **Insured's Insurance ID or SS#**: _____

Insured's Name: _____ **Relationship to You**: _____

Medical History

How long has it been since you visited a dentist? _____ Previous Dentist: _____

Do you have a any allergies we should be aware of? _____

Are you currently under the care of a physician? Please explain: _____

Please list all/any prescription medications/over the counter you are taking? _____

Do you smoke or use tobacco? _____ Are you pregnant or nursing? _____

Do/Have you taken Bisphophonates (Gosamax, Actonel, Aredia, Didronel etc): _____

Physician's name/Phone/Emergency Contact: _____

Have you ever had any of the following?

Y	N	Abnormal Bleeding	Y	N	Frequent Headaches	Y	N	Mitral Valve Prolapse
Y	N	Alcohol/Drug Abuse	Y	N	Glaucoma	Y	N	Pacemaker
Y	N	Anemia	Y	N	Hay Fever	Y	N	Psychiatric Problems
Y	N	Arthritis	Y	N	Heart Attack	Y	N	Radiation Treatment
Y	N	Artificial Bones/Joints/Valves	Y	N	Heart Murmur	Y	N	Rheumatic / Scarlet Fever
Y	N	Asthma	Y	N	Heart Surgery	Y	N	Seizures
Y	N	Blood Transfusion	Y	N	Hemophilia	Y	N	Shingles
Y	N	Cancer/Chemo	Y	N	Hepatitis	Y	N	Sickle Cell
Y	N	Colitis	Y	N	Herpes	Y	N	Sinus Problems
Y	N	Congenital Heart Defect	Y	N	High Blood Pressure	Y	N	Stroke
Y	N	Diabetes	Y	N	HIV+/AIDS	Y	N	Thyroid Problems
Y	N	Difficulty Breathing	Y	N	Hospitalized	Y	N	Tuberculosis
Y	N	Emphysema	Y	N	Kidney Problems	Y	N	Ulcers
Y	N	Epilepsy	Y	N	Liver Disease	Y	N	Venereal Disease
Y	N	Fainting Spells	Y	N	Low Blood Pressure	Y	N	Acid Reflux / Indigestion

Why have you come to the dentist today? _____

Do you have a CPAP Sleep Apnea Machine? _____ How often do you use it? _____

Are you experiencing any pain near your teeth or jaw? _____

Do your gums bleed? _____ How often do you brush / Floss a day? _____

What type of brush do you use? Soft Medium Hard

Do you want whiter teeth? Yes No Do you want fresher breath? Yes No

On a scale of 1 to 10 (10=perfect) how would you rate your smile? 1 2 3 4 5 6 7 8 9 10

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services that I may need during the diagnosis and treatment with my informed consent.

_____

Signature Date