BARBARA MALLONEE DDS, INC

Health History

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's date: _____ /_____ /_____
MM DD YY

Social Security # ________ - _____ - ________

Name: ____
Last First Middle Initial

I like to be called: ______________________________

Home Address: ____________________________________

____
Apt / Condo# City State Zip

Birthdate: _____ /_____ /_____
MM DD YY

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Special interests, sports, or hobbies: ________________

____

Referred by: ______________________________________

Occupation: ______________________________________

Your Employer: ___________________________________

Address: _________________________________

____
City State Zip

DENTAL INSURANCE

Do you have dental insurance through your employer? ☐ Yes ☐ No

If yes, please provide the following information:

Dental Insurance Co. #1: ___________________________

Group # ____

Insurance Co. Phone # (_____) ______________________

Employer's Name: __________________________________

Do you have other Dental Coverage? ■ Yes ■ No

This coverage is through: ☐ Spouse ☐ Parent ☐ Other

Their Name: ______________________________________

Their Employer: ___________________________________

Their Social Security # ________ - _____ - ________

Their Birthdate: _____ /_____ /_____
MM DD YY

Dental Insurance Co. #2: ___________________________

Insurance Co. Phone # (_____) ______________

Group # __________________________

CONTACT

Cell # (_____) ____________________

Home Phone # (_____) ____________________

Work Phone # (_____) ____________________ Ext # _________

Email: ____

When is the best time to reach you? ______________________________

Where? ______________________________ Specific days? ______________

In the event of an emergency, is there someone who lives near you that we could contact?

Name: __________________ Relationship: ______________ Phone # ________________________

MEDICAL HISTORY

Do you have a personal physician? Y N

Physician Name: ______________________

Physician Phone # (_____) ______________________

Approximate date of last visit: ______________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of any physician? Y N

If yes, please explain: ______________________

Do you smoke or use tobacco in any other form? Y N

Are you presently taking any drugs prescribed by a physician or dentist? Y N

If yes, please list: ______________________

Have you ever been diagnosed with Sleep Apnea? Y N

If yes, do you wear a CPAP? Y N

Other treatment? ______________________

For Women: Are you pregnant? Y N Week # ________

Do you need to be premedicated before dental treatment?
☐ Yes ☐ No

Have you had any serious medical problems in the last 5 years? Y N

If yes, please explain: ______________________

____

Please circle any of the following that apply

Anemia
Cancer / Chemotherapy
Chronic Hepatitis
Diabetes
Drug / Alcohol Abuse
Epilepsy / Seizures / Fainting Spells
Fever Blisters / Herpes
Heart Attack / Stroke
Heart Murmur / Rheumatic Fever
Heart Surgery / Pacemaker
Hemophilia / Abnormal Bleeding
High / Low Blood Pressure
HIV+ / AIDS
Kidney Problems
Psychiatric Problems
Severe Headaches
Shingles
Sickle Cell Disease / Traits
Sinus Problems
Tuberculosis

Any other serious medical issues not listed above? ______________________

____

OFFICE USE ONLY Doctor's comments: ______________________

____

____

Are you allergic to any of the following drugs?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromcin
Y N Penicillin
Y N Tetracycline

Please list any other drugs you are allergic to: ______________________

____

DENTAL HISTORY

Why have you come to the dentist today? ______________________

____

Are you curently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Do you experience stress or anxiety when you visit a dental office? Y N

The approximate date of your last dental visit: ______________

Have you ever experienced TMJ problems? ☐ Yes ☐ No
(TMJ is pain or discomfort in your jaw joints)

Do you grind your teeth? Y N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Would you like to prevent dentures? Y N

Payment is due in full at the time of treatment unless prior arrangements have been made

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 in my medical status.

____

Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Remember...

STOP SMILING AND THE COMMUNICATION ENDS!

Our offfice is HIPPA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

BARBARA MALLONEE DDS, INC

Payment & Cancellation Policy

It is the policy of this office that full payment is made for your care at the time of each visit. You may pay by cash, check, credit card, or make arrangements through one of our outside billing services. A late charge of $25.00 and a service charge of 1.5% per month (18% per annum) on any unpaid balance will be charged on all accounts that exceed 30 days, unless previously written financial arrangements are satisfied. Whenever treatment is necessary, we will create a written financial arrangement.

As a courtesy to our guests with dental insurance, we will complete and submit our insurance claims for you. However, we do not accept assignment of benefits for dental insurance.

How will you be paying for your dental care?

- Cash _____
- Check _____
- Major Credit Card ________________________________ Exp. ___________
- Outside Billing Service (credit application required) _____

When you make an appointment we reserve that time solely for you. Please make every effort possible to keep your appointments. An office visit fee up to the amount of the scheduled procedure(s) will be charged for all appointments not kept unless you cancel or reschedule at least 48 hours in advance.

I understand and agree to this Payment and cancellation Policy.
I authorize Barbara Mallonee, DDS, Inc. to keep my signature on file and to charge the above credit card for treatment rendered.

____
Name

____ ________________________
Signature Date

Barbara Mallonee, DDS, Inc.
2121 East Coast Highway Suite 140 Corona del Mar, CA 92625
Tel 949 640-0222 **Fax** 949 640-0333 **drmallonee.com**

BARBARA MALLONEE DDS, INC

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0 = never, 1 = slight, 2 = moderate, 3 = high chance of dozing)
CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
Driving a car stopped for a few minutes in traffic	0	1	2	3
Sitting & talking to someone	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Total Score: _____

Section 2: Patient Evaluation

Please circle yes or no response for each question	No (0)	Yes (1)
BMI (See attached chart): _______ Is it greater than or equal to 30? _______	0	1
Neck circumference: _______ Is it > 17" (Men) or > 15" (Women)? _______	0	1
Have you gained at least 15 lbs. in the past 6 months?	0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle yes or no response for each question	No (0)	Yes (1)
Do you snore?	0	1
You, or your partner, would consider you snoring louder than a person talking	0	1
Your snoring occurs almost every night	0	1
Your snoring is bothersome to you bed partner	0	1
Do you feel that in some way your sleep is not refreshing or restful?	0	1
Do you wake up at night or in the mornings with headaches?	0	1
Do you experience fatigue during the day and have difficulty staying awake?	0	1
Do you have trouble remembering things or paying attention during the day?	0	1
Do you have high blood pressure?	0	1

Total Score: _____

Section 4: Prior Diagnosis

Have you previously been diagnosed with sleep apnea? ________

If Yes:

When were you diagnosed? (Approximate MO/YR) ________

Were you put on CPAP therapy for treatment? ________

Are you still using your CPAP every night? ________

Total Score: _____

(Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate on back of page if necessary)

OFFICE USE ONLY

Advanced screening criteria: If yes to any below, Pt. should be scheduled for advanced OSA screening.

_____ESS Score ≥ 8? ______Pt. Eval > 2? ______ Subjective Sleep Eval ≥ 3? ______Prior OSA Diagnosis ≥ 1?

BARBARA MALLONEE DDS, INC

Symptoms Screening Form

Name ______________________ **Age** ____ **Sex** ____ **Date** ____________

Please circle any of the following symptoms you may have:

HEAD/FACE

1. Forehead
2. Temporal
3. Tension headaches
4. Migraine headaches
5. Sinus headaches
6. Back of head headaches
7. Hair scalp tender to touch

NASAL

1. Sinus pain
2. Sinus problems
3. Post nasal drainage
4. Allergies

EAR

1. Ear pain without infection
2. Decreased hearing
3. Clogged, itchy or stuffy
4. Ringing, buzzing
5. Dizziness
6. Balance problems

EYES

1. Pain in/around eyes
2. Bloodshot eyes
3. Sensitive to light
4. Tearing of eyes
5. Blurred vision
6. Pressure behind eye

THROAT

1. Swelling difficulties
2. Feeling of foreign object in throat
3. Sore throat without infection
4. Voice changes
5. Laryngitis
6. Frequent coughing or clearing

NECK

1. Lack of mobility
2. Stiffness
3. Neck pain
4. Tired/sore neck muscles
5. Shoulder pain
6. Back pain: middle, lower
7. Arm/finger pain/numbness

JAW

1. Jaw pain
2. Jaw joint pain
3. Clicking/popping jaw joint
4. Grating sound in jaw joint
5. Pain in cheek muscles
6. Uncontrollable jaw movements
7. Jaw locks open/shut
8. Deviates to one side on opening or closing

MOUTH

1. Abnormal opening
2. Limited opening
3. Bad bite
4. Missing teeth
5. Excessive mouth breathing
6. Clench or grind teeth
7. Mouth discomfort
8. Inability to find “bite”

Acknowledgment of Receipt of Privacy Notice and Dental Material Fact Sheet

This document acknowledges that you have received a copy of or have been given access to:

1. Notice of Privacy Practices
2. Dental Material Fact Sheet (available in our office or at the following web site: http://www.dbc.ca.gov/formspubs/put_dmfs2004.pdf

This document is not a contract, authorization, or release form. This document will remain in your records.

- ☐ From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check here if you do NOT wish to be notified of such events.
- ☐ E-mail address ____

I, ____, acknowledge that I have received a copy of the Notice of Privacy Practices and the Dental Material Fact Sheet.

____ ____________________

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

____ ____________________

Parent or Legal Guardian Date

____

Relationship to Patient

Barbara Mallonee, DDS, Inc.

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvements activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including, identifying, or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in our healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Consent

I acknowledge that the Practice has explained to me in general terms, the diagnosis of my condition, the basis for their Treatment plan recommendations, the alternatives (including non-treatment) and the risks and inconveniences. I have been given the opportunity to ask any questions and any such questions have been answered or explained to my satisfaction.

By signing below, I acknowledge that I have been given time to read and have read the preceding information in this document and I agree to assume the risks and any inconveniences of my treatment.

I consent to the making of records, including x-rays, photographs, prescriptions, and other information, which may include for treatment: payment, or healthcare operations, including disclosure of personal information before, during, and after treatment (together “Records”). The Practice may disclose my Records to laboratories, other dental offices or professionals involved in my care, and to my insurance providers.

I understand this form and consent to performance of the Treatment Plan as described herein.

Patient Name:	Signature:	Date:

Patient’s Authorized Representative

(If patient is under 18 years of age, or your consenting to the care of another)
I have the legal authority to sign this consent on behalf of:

Patient Name:		
Your Relationship to Patient:	Signature:	Date:

BARBARA MALLONEE DDS, INC

I, ____, hereby authorize Dr. Mallonee and/or assistant to take photographs, slides and/or videos of my body, face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications.

In addition, they may be presented on Dr. Mallonee's website, or any other social media video sites for reasonable marketing purposes.

I further understand that if photographs, slides, and/or video are used for any marketing purposes, publications, or as part of any demonstrations, all reasonable attempts will be made to conceal my identity.

____

PATIENT'S SIGNATURE DATE:

____

IF A MINOR, SIGNATURE OF GUARDIAN OR PARENT DATE:

____

DOCTOR'S SIGNATURE DATE:

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such life style risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancer causes. * Oral cancer risk by patient profile as follows:

Increased risk: patients ages 18-39
-sexually active patients (HPV)

High risk: patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)

Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope powered by Sapphire into our oral screening standard of care. We find that using VELscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is ____________.

❐ Yes. I would prefer to have the VELscope powered by Sapphire exam at this time.

❐ No. I would prefer not to have the VELscope powered by Sapphire exam at this time.

Print Name ____

Signature ____ Date _________________________________

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DRIVING DIRECTIONS

We are located just north of MacArthur Blvd, on the northwest corner of Coast Highway and Avocado. Turn west on Avocado and make your first right into the parking garage (Coast Business Center).
Take the elevator to the "G" level. Walk through courtyard to Suite 140.

Barbara Mallonee, DDS, Inc.
2121 East Coast Highway   Suite 140   Corona del Mar, CA 92625
Tel 949 640-0222   **Fax** 949 640-0333 **drmallonee.com**