LESLIE NASON, DDS

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form to the best of your ability. If you have any questions or need assistance, please let us know for we will be happy to help.

Patient Information *information provided will remain confidential* Date_____

Name_____ Birthdate_____ Email_____

Address_____City_____State_____Zip_____

Primary Phone_____ ☐ Cell ☐ Home ☐ Work

Secondary Phone_____ ☐ Cell ☐ Home ☐ Work

Check Appropriate: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Preferred method of contact (circle one): Phone Text Email Mail Gender (circle one): Male Female

Whom May We Thank for Referring You?_____

Emergency Contact Name:_____Phone:_____

Responsible Party

Name of Responsible Party_____ Relationship to Patient_____
Address_____ City_____ State_____ Email _____
Primary Phone_____ ☐ Cell ☐ Home ☐ Work

Secondary Phone_____ ☐ Cell ☐ Home ☐ Work

Birthdate_____ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

We must stress that your dental insurance may not pay the entire cost of your treatment. For your convenience, we offer the following methods of payment.

~ Cash ~ Personal Check ~ VISA/MC

If you do not have dental insurance we also have alternative financing options below.

~ Compassionate Care ~ In Office Membership

Insurance Information

Primary Insurance Holder_____ Relationship to Patient_____

Birthdate_____SS#_____Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Group#_____Policy/ID#_____

Ins. Co. Address_____City_____State_____Zip_____

Insurance Company Phone Number_____

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Patient Medical History

Primary Care Physician_____ Phone_____ Date of Last Exam_____

Are you under medical treatment now?.....	YES	NO	Do you use controlled substances?	YES	NO
Are you wearing contact lenses?	YES	NO	Do you use tobacco (smoke, vape, or dip)?	YES	NO
Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain: _____ _____	YES	NO	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?.....	YES	NO
Are you allergic to or have you had any reactions to the following: Local Anesthetics (e.g. Novocain)…….... Penicillin or any other Antibiotics…...…… Sulfa Drugs……..…. Barbiturates, Sedatives, or Sleeping Pills ……... Iodine……..…... Aspirin……..… Latex Rubber……. Others (please list) _____	YES YES YES YES YES YES YES YES	NO NO NO NO NO NO NO NO	Are you taking any medications(s) including non-prescription medicine?..... If yes, what medication(s) are you taking? _____ _____ _____ _____ _____	YES	NO

Name of Previous Dentist _____Date of Last Exam_____

Do your gums bleed while brushing?	YES	NO	Do you clench or grind your teeth?	YES	NO
Do you feel any pain	YES	NO	Do you bite your lips or cheeks frequently?	YES	NO
Are your teeth sensitive to sweet or sour liquids/foods?.....	YES	NO	Have you ever had any difficult extractions in the past?.....	YES	NO
Are your teeth sensitive to hot or cold liquids/foods?	YES	NO	Have you ever had any prolonged bleeding following extractions?.....	YES	NO
Do you have any sores or lumps in/or near your teeth?.....	YES	NO	Do you wear dentures or partials?.. If yes, how long have you had it? _____ years old	YES	NO
Have you had any head, neck, or jaw injuries?.....	YES	NO	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	YES	NO
Have you ever experienced any of the following problems in your jaw: Clicking…….. Pain (joint,ear,side of face)…… Difficulty in opening or closing…….. Difficulty chewing…… Do you have frequent headaches?...	YES YES YES YES YES	NO NO NO NO NO	Do you have a crown or a bridge?..... If yes, how long have you had it? _____ years old	YES	NO

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Kidney Disease	YES	NO	Liver Disease	YES	NO
Cancer	YES	NO	Leukemia	YES	NO
Hepatitis/Jaundice	YES	NO	Radiation Therapy	YES	NO
Sexually Transmitted Disease	YES	NO	Emphysema	YES	NO
AIDS or HIV Infection	YES	NO	Chronic Headaches	YES	NO
Dry Mouth	YES	NO	Atrial Fibrillation	YES	NO
Jaw Discomfort	YES	NO	Fibromyalgia	YES	NO
Grinding Teeth (Bruxism)	YES	NO	Tuberculosis	YES	NO
Thyroid Problems	YES	NO	Arthritis	YES	NO
Depression	YES	NO	Memory Loss	YES	NO
ADD/ADHD	YES	NO	Asthma	YES	NO
Fainting/Seizures	YES	NO	Rheumatic Fever	YES	NO
Epilepsy/Convulsions	YES	NO	Hay Fever/Allergies	YES	NO
Low Blood Pressure	YES	NO	Chest Pains	YES	NO
Swollen Ankles	YES	NO	Easily Winded	YES	NO
Joint Replacement or Implant	YES	NO	Respiratory Problems	YES	NO
GERD (Acid Reflux)	YES	NO	Angina	YES	NO
Stomach Troubles/Ulcers	YES	NO	COPD	YES	NO
Recent Weight Loss	YES	NO	Heart Trouble	YES	NO
Anemia	YES	NO	Renal Failure	YES	NO
Stroke	YES	NO	Heart Failure	YES	NO
Glaucoma	YES	NO	Mitral Valve Prolapse	YES	NO
Restless Leg Syndrome (RLS)	YES	NO	Heart Trouble	YES	NO
Snoring	YES	NO	Heart Murmur	YES	NO
Frequently Tired	YES	NO	Cardiac Pacemaker	YES	NO
Fatigue/Hypersomnia	YES	NO	Heart Attack	YES	NO
Restless Sleep	YES	NO	Hypertension (High Blood Pressure)	YES	NO
Night Sweats	YES	NO	Diabetes	YES	NO
Insomnia	YES	NO	Heart Disease	YES	NO
Frequent Urination at Night	YES	NO	Obesity/Overweight	YES	NO

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Women Only:

A) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
B) Are you nursing? ☐ Yes ☐ No
C) Are you taking oral contraceptives? ☐ Yes ☐ No

Oral Cancer:

A) Have you ever been diagnosed or have a family history of Oral Cancer? ☐ Yes ☐ No
B) Have you ever been diagnosed or have a family history of HPV? ☐ Yes ☐ No
C) Do you currently use any tobacco products, or have used them in the past? ☐ Yes ☐ No
D) Do you use e-cigarettes or do you use vapor devices? ☐ Yes ☐ No
E) Do you regularly consume alcoholic beverages? ☐ Yes ☐ No

Is there anything else that you think your dental healthcare provider should know about? Please Explain:

_____
_____
_____

Lastly, Do you like your smile?..... ☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay insurance benefits directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature of patient (or parent/guardian if minor) Date

Doctor's Comments:
_____
_____
_____

Signature:_____Date_____

Written Financial Policy

Thank you for choosing Leslie A. Nason, DDS PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to beginning dental care.

- Low Monthly Payment options through Compassionate Financing
    - Guaranteed credit approval (interest rate varies)
    - Low-cost monthly financing to fit any budget

We also offer in-house financing. We accept payment in thirds for treatments over $500. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of 3 hours or more, a 20% non-refundable deposit is required to secure your initial treatment appointment.

We charge 18% interest annually on all accounts over 60 days.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

A fee of $56 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Leslie A. Nason, DDS PC charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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Medical History Update
Apnea Evaluation

Patient Name:_____ DOB:_____

Gender:_____ Height:_____ Weight:_____ BP:_____/_____ BMI:_____

Please check any of the following you may have (or suffer from):

□ Diabetes	□ Heart Failure	□ Chronic Pain
□ Frequent Urination at Night	□ Morning Headaches	□ Insomnia
□ Renal Failure	□ Overweight	□ Grinding Teeth (Bruxism)
□ Erectile Dysfunction	□ Stroke	□ Hypertension
□ Atrial Fibrillation	□ Depression	□ GERD (Acid Reflux)
□ Heart Disease	□ ADHD	□ Other _____

Circle the number that most applies to you:

Epworth Sleep Scale	Never doze off	Slight chance of dozing off	Moderate chance of dozing off	High chance of dozing off
1. Do you get sleepy, or doze off while sitting and reading?	0	1	2	3
2. Do you get sleepy, or doze off while watching TV?	0	1	2	3
3. While sitting or inactive in a public place?	0	1	2	3
4. As a passenger in a car for more than an hour without a break?	0	1	2	3
5. Lying down to rest in the afternoon?	0	1	2	3
6. Sitting and talking to someone?	0	1	2	3
7. Sitting quietly after lunch without alcohol?	0	1	2	3
8. In a car, while stopped for a few minutes at a traffic light?	0	1	2	3

Total Score: _____

Please check which applies:

1. Do you snore *or* have been told that you snore?	□Yes	□No
2. Do you often feel tired, fatigued, or sleepy during the daytime?	□Yes	□No
3. Has anyone observed you stop breathing or gasping for air during your sleep?	□Yes	□No
4. Do you have or are you being treated for high blood pressure?	□Yes	□No
5. Do you have or are you being treated for GERD (acid reflux)?	□Yes	□No
6.Have you ever been diagnosed with Sleep Apnea?	□ Yes	□ No
7.Are you currently using a CPAP (or any other apnea/snoring device)?	□ Yes	□ No
8.Are you currently taking any sleep aids (prescribed or OTC)?	□ Yes	□ No
9.Are you currently taking any prescribed pain medication?	□ Yes	□ No
10.Are you aware of clenching and grinding your teeth?	□ Yes	□ No

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Acknowledgement of Receipt of

Notice of Privacy Policies

I, _____, have received a copy of
Dr. Nason's Notice of Privacy Policies.

_____
Name (print)

_____ _____
Signature Date

OFFICE USE ONLY

On_____, an Acknowledgement of Receipt of Notice of Privacy Policies form was delivered. The form was not signed due to:

___ Communication barriers which prevent acknowledgement

___ An emergency which prevent acknowledgement

___ A refusal to sign

___ Other_____