Welcome!

DENTISTRY

Patient Information

Patient Name: _____ (Last / First / Middle Initial) Preferred Name: _____

Street Address: _____ (Street / City / State / Zip)

If student, permanent address: _____

Date of Birth: ____/____/_____ Driver's License No. _____

Employer: _____ Social Security #: _____-_____-_____

Home Phone: _____ Work Phone: _____ Ext: _____

Other: _____ Cell Phone: _____

Email Address: _____

Would you like us to send you an email or text message to remind you of your appointments?

Yes ☐ No ☐ If not we will call you the day before to confirm your appointment.

Please consider other patients and give at least 24 hours notice to change your appointment.

Spouse/Guardian Name: _____ DOB _____ SS# _____

Spouse's Employer: _____

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

Person to contact in case of emergency: _____

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

Whom may we thank for sending you to our office? _____

Insurance Information

Please note we are not a participating provider for any insurance network.

Primary Dental Insurance: _____ Phone: _____

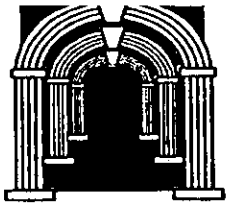
Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/_____

Subscriber's SS# or ID#: _____/_____/_____ Group#: _____

Secondary Dental Insurance: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/_____

Subscriber's SS# or ID#: _____/_____/_____ Group#: _____



J. Craig Scasta, DDS
Robert A. Hall, DDS

Symptom Check List

Patient Name_____ **Date**_____

Please check any of the following symptoms which may apply to you.

Headaches

- ☐ Migraines ☐ Tension Headaches
- ☐ Other _____
- ☐ How Often? _____

☐	Top of Head	☐ Left Side	☐ Right Side
☐	Forehead	☐ Left Side	☐ Right Side
☐	Back of Head (occipital)	☐ Left Side	☐ Right Side
☐	Temples	☐ Left Side	☐ Right Side
☐	Behind Eyes	☐ Left Side	☐ Right Side
☐	Pain in Neck	☐ Left Side	☐ Right Side
☐	Pain in Ear	☐ Left Side	☐ Right Side
☐	Dizziness (vertigo)	☐ Left Side	☐ Right Side
☐	Pain in jaw Joint	☐ Left Side	☐ Right Side
☐	Clicking or Popping Sound in Joint	☐ Left Side	☐ Right Side
☐	Pain in shoulder	☐ Left Side	☐ Right Side
☐	Ear congestion	☐ Left Side	☐ Right Side
☐	Tinnitus (ringing sound in ears)	☐ Left Side	☐ Right Side
☐	Facial Pain (nonspecific)	☐ Left Side	☐ Right Side
☐	Grating sound in Joint	☐ Left Side	☐ Right Side

Partial inability to open mouth	☐ Yes	☐ No
Face Muscle twitch	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Difficulty breathing through nose	☐ Yes	☐ No
Difficulty chewing	☐ Yes	☐ No

Occlusal Habits

- ☐ Clenching ☐ AM ☐ PM
- ☐ Grinding on teeth ☐ AM ☐ PM
- ☐ Teeth hit in front first
- ☐ Gum chewing
- ☐ Pencil biting
- ☐ Cheek biting
- ☐ Pipe smoking
- ☐ Nail biting
- ☐ Other _____

Postural Habits

- ☐ Phone cradling
- ☐ TV watching
- ☐ Shoulder bag
- ☐ Leans chin on hand
- ☐ Heavy lifting
- ☐ Pipe smoking
- ☐ Nail biting
- ☐ Other _____

Additional Comments

_____
_____
_____
_____
_____
_____
_____
_____

List any medications which have caused an allergic reaction:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:

_____
_____
_____
_____

List any medications you are currently taking:

Y☐ N☐ Antacids
Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Antidepressants
Y☐ N☐ Anti-inflammatory drugs (non-steroid)
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ High blood pressure medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other current medications: _____
_____
_____

Medical History

Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Chronic sinus problems
Y☐ N☐ Chronic fatigue
Y☐ N☐ Congestive heart failure
Y☐ N☐ Current pregnancy
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent sore throats
Y☐ N☐ Frequently awakens with a dry mouth
Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
Y☐ N☐ Hay fever
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pounding or beating irregularly during the night
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Neck
☐ Head ☐ Mouth ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nighttime sweating
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Thyroid problems
Y☐ N☐ Tonsillectomy (have had)
Y☐ N☐ Wisdom teeth extraction

Other medical history:

_____
_____
_____
_____

Patient Signature _____ Date _____

Patient Name: _____ Date: _____

ASSESSMENT OF DAYTIME SLEEPINESS
EPWORTH SLEEPINESS SCALE

Please complete the questions below. This is a measure of dosing or falling asleep, not just feeling tired. This is to reflect how you have felt most recently.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

It is important that you put a number (0-3) in each of the 8 boxes.

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place, for example, a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting an talking to someone	
Sitting quietly after lunch (when you've had no alcohol	
In a car, while stopped in traffic	

Height : _____

Weight: _____

BMI: _____

Neck Circumference (measured by staff)

_____cm

Stop Bang Questionnaire

Snoring: Do you snore loudly (Louder than talking or loud enough to be heard through closed doors)
Yes **No**

Tired: Do you often feel tired, fatigued, or sleepy during the day?
Yes **No**

Observed: Has anyone observed that you stop breathing during your sleep?
Yes **No**

Blood Pressure: Do you have or are you being treated for high blood pressure?
Yes **No**

BMI more than 35 kg/?
Yes **No**

Age over 50 years?
Yes **No**

Neck circumference greater than 40 cm?
Yes **No**

Gender, Male?
Yes **No**

PATIENT RECORDS REQUEST FORM

J. Craig Scasta, DDS, PA
Robert A Hall, DDS, Inc.
1615 Barak Lane
Bryan, TX 77802
Ph: 979-260-2626 / Fax: 979-260.2631

This form entitles our office to request any necessary records from previous dentist, and or physicians if needed.

Name of Patient Whose Record is Requested_____

DOB_____ Phone_____

Address _____ City/State/Zip_____-----_____

Please provide a copy of the record as indicated below:

☐ The full health record maintained by this provider/practice

☐ The health record for the following time frame: _____ through _____

☐ A specific section of the health record as described below:

_____

_____

_____

☐ A summary of the information requested above is adequate to fulfill this request.

☐ As permitted by federal and state law, I understand that a fee of _____ cents per page will be charged for copying the records along with a clerical fee of _____. In addition, a fee of _____ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date_____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

J. Craig Scasta, DDS, PA
Robert A Hall, DDS, Inc.
1615 Barak Lane, Suite #2
Bryan, TX 77802
979-260-2626

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Submit form

J. Craig Scasta, D.D.S. and Robert A. Hall, D.D.S.
1615 Barak Lane Suite 2, Bryan, Tx. 77802
Phone: (979) 260-2626

FINANCIAL POLICY

Thank you for choosing our practice as your dental care provider! We look forward in beginning our dental friendship together and are committed to your treatment being successful! Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **FINANCIAL POLICY,** which we require you to read and sign before treatment.

DENTAL INSURANCE / MEDICAL INSURANCE

Insurance is a contract between you and your insurance company. We are NOT CONTRACTED with ANY insurance company and are considered OUT OF NETWORK. We will assist you in filing and will accept assignment of DENTAL BENEFITS. However, if your insurance has not paid within sixty (60) days from the date of service you will be sent a statement and payment is expected by the due date.

WE ARE NOT A MEDICAID OR MEDICARE PROVIDER.

USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENT

Payment is due at the time of service. In the event you are sent a statement then payment is due by the due date. We accept CHECK, CASH, VISA/ MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.

If you have any questions regarding this financial policy please feel free to ask one of our team members. Welcome to our practice and we look forward in beginning our dental friendship!

Patient / Guardian signature: _____