PARMAR
FAMILY & COSMETIC DENTISTRY

12620 Clarksville Pike (Route 108)
Clarksville, MD 21029
Phone: (410) 531-5639
Fax: (410) 531-6625
www.ParmarDMD.com

1. PATIENT INFORMATION

Name: _____ SS# _____ Date: _____
First Name Last Name

Address: _____

City: _____ State: _____ Zip: _____

Wish to be Called: _____ Responsible Party: _____
Name/Relationship

Sex: ❑ M ❑ F Birth Date: _____ Age: _____ years

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced

Occupation: _____ Employer / School Phone: _____

Employer/School Address: _____

Spouse's Name: _____ Spouse's Birth Date: _____ Spouse's SS# _____

Spouse's Employer/Address: _____

How did you hear about our office? _____

2. INSURANCE INFORMATION - DENTAL

Subscriber's Name: _____ Subscriber's Birth Date: _____ Subscriber's SS# _____

Relationship to Patient: _____

Insurance Company: _____ Ins. Comp. Phone: _____

Policy/Group # _____ Insurance Comp. Address: _____

Is there any additional dental insurance: ❑ Yes ❑ No

INSURANCE INFORMATION – MEDICAL

Subscriber's Name: _____ Subscriber's Birth Date: _____ Subscriber's SS# _____

Relationship to Patient: _____

Insurance Company: _____ Ins. Comp. Phone: _____

Policy/Group # _____ Insurance Comp. Address: _____

ASSIGNMENT AND RELEASE

I understand that Dr. Parmar does not participate with many insurance companies and that reimbursements will come either to the office or to me directly depending on your insurance contract. Regardless of where the reimbursements go, I will be responsible for any and all charges for all work done and/or all services provided by Dr. Parmar and her office.

Dr. Parmar may use my healthcare information and may disclose such information to insurance companies and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits for related services.

Signature of Patient, Parent, Guardian or Personal Representative: _____

Date: _____ Relationship to Patient: _____

3. CONTACT INFORMATION

Home: _____ Cell: _____ Work: _____

Primary E-Mail: _____ Alt. Email: _____

In Case of Emergency – Contact: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

4. DENTAL HISTORY

Date of Last Dental Visit: _____ Reason for today's visit: _____

Any special concerns? _____

Are you fearful: ❑ Yes ❑ No If "Yes", Rate you fear 1-10 (1 least, 10 High) _____

Did you have any bad experience or reason for the fear?

Explain:

Place a mark to indicate if you have any of the following:

❑ Clenching Teeth	❑ Orthodontic treatment	❑ Bad breadth	❑ Blisters on lips or mouth
❑ Clicking or popping jaw	❑ Pain around ear	❑ Bleeding gums	❑ Burning sensation on tongue
❑ Nail biting/Thumb-sucking	❑ Ringing in the ears	❑ Dry mouth	❑ Chew on one side of mouth
❑ Grinding Teeth	❑ Sensitivity to biting	❑ Food collection betw'n teeth	❑ Loose teeth or broken fillings
❑ Headaches	❑ Sensitivity - hot/cold, sweets	❑ Gums swollen or tender	❑ Sores or growths in mouth
❑ Jaw pain or tiredness	❑ Vertigo/Dizziness	❑ Mouth breathing	❑ Tingling in arms/fingers
❑ Lip or Cheek biting	❑ Difficulty chewing	❑ Periodontal treatment	❑ OTHER

5. HEALTH HISTORY

Physician's Name: _____ Phone # _____ Date of last full physical: _____

Place a mark to indicate if you have any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
			❑	❑	Congenital Heart Lesions						
❑	❑	AIDS/HIV				❑	❑	Kidney Disease	❑	❑	Stroke
❑	❑	Anemia	❑	❑	Cortisone Treatments	❑	❑	Liver Disease	❑	❑	Swollen Feet or Ankles
❑	❑	Arthiritis, Rheumatism	❑	❑	Cough, persistent or bloody	❑	❑	Low Blood Pressure	❑	❑	Swollen Neck Glands
❑	❑	Artificial Heart Valves	❑	❑	Diabetes	❑	❑	Nervous Problems	❑	❑	Thyroid Problems
❑	❑	Artificial Joints	❑	❑	Emphysema	❑	❑	Pacemaker	❑	❑	Tonsillitis
❑	❑	Asthma	❑	❑	Epilepsy	❑	❑	Psychiatric Care	❑	❑	Tuberculosis
❑	❑	Back Problems	❑	❑	Fainting or dizziness	❑	❑	Radiation Treatment	❑	❑	Tumor or growth on Head / neck
❑	❑	Bleeding abnormally with Extraction or surgery	❑	❑	Glaucoma	❑	❑	Respiratory Disease			
			❑	❑	Heart Problems	❑	❑	Infective Endocarditis	❑	❑	Ulcer
❑	❑	Blood Disease	❑	❑	Hepatitis Type _____	❑	❑	Scarlet Fever	❑	❑	Venereal Disease
❑	❑	Cancer	❑	❑	Herpes	❑	❑	Shortness of Breath	❑	❑	Weight loss, unexplained
❑	❑	Chemical Dependency	❑	❑	High Blood Pressure	❑	❑	Sinus Trouble	❑	❑	
❑	❑	Chemotherapy	❑	❑	Jaundice	❑	❑	Skin Rash	Weight _____lbs		
❑	❑	Circulatory Problems	❑	❑	Jaw Pain	❑	❑	Special Diet	Height _____ft. ____in.		

Do you use tobacco products? ❑ Yes ❑ No If Yes, what and how often, how long? _____

Do you use antidepressants or sleeping pills? ❑ Yes ❑ No If yes, list name(s) _____

❑ ❑ Sleep Apnea ❑ ❑ C Pap ❑ ❑ Have you had sleep Studies ❑ ❑ Have you seen ENT

❑ ❑ Do you snore ❑ ❑ ❑ ❑ Have you seen chiropractor ❑ ❑ Have you seen neurologist

Are you on any blood thinners, including Asprin? ❑ Yes Mg ❑ No

Are you currently taking or have taken any of the following medications?

Yes	No		Yes	No		Yes	No	
❑	❑	Alendromate-Fosomax-oral	❑	❑	Ibandrote-Boniva-oral	❑	❑	Tiludronate-Skelid-oral
❑	❑	Clodronate-Ostac, Bonefos-IV & oral	❑	❑	Pamidronate-Aredia-IV	❑	❑	Zoledronic acid – Zometa-IV
❑	❑	Etidronate-Didronal-IV and oral	❑	❑	Risedronate-Actonel-oral	❑	❑	Other

Women: Are you pregnant? ❑ Yes ❑ No If yes, when is your due date? _____

Taking birth control pills? ❑ Yes ❑ No Are you taking hormones? ❑ Yes ❑ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

❑ Vitamins / Minerals ❑ Herbs

Pharmacy Name: _____ Phone: _____

Are you allergic to?

❑ Aspirin ❑ Latex ❑ Penicillin

❑ Codeine ❑ Local Anesthetic ❑ None

❑ Lodine ❑ Sulfa ❑ Other

❑ Barbiturates (Sleeping pills) ❑ _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Patient/Parent/Guardian Signature: _____ Date: _____

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#

TMJ Questionnaire

What are the chief complaints for which you are seeking treatment?

ORDER	FREQUENCY	INTENSITY
Please rate your chief complaints by number: **#1** – being the most important **#2** – the 2nd most important **#3** – 3rd important, **#4, #5, #6**… etc. (List all please)	Rate your chief complaints for frequency as follows: 1 = Seldom 2 = Occasional 3 = Frequent 4 = Everyday	Rate the intensity of each complaint on a scale from 1 to 10. 0 = No pain 10 = Most severe pain

Chief Complaint	ORDER	FREQUENCY 1 – 4	INTENSITY 0 – 10
Jaw clicking / popping			
Jaw joint noises			
Jaw locking			
Jaw pain			
Muscle twitching/soreness			
Limited mouth opening			
Dizziness			
Headaches			
Visual disturbances			
Facial pain			
Ear pain			
Back pain			
Eye pain			
Neck pain			
Pain when chewing			
Throat pain			
Ear congestion			
Sinus congestion			
Ringing in the ears			
Fatigue			

Patient Initials:_____ Date:_____

…..because your smile matters. #

#

SYMPTOMS: Please indicate location and type of any head pain

L=Left, R=Right, B=Both

HEAD PAIN	LOCATION	SEVERITY			FREQUENCY			DURATION				
		Mild	Moderate	Severe	Occasional (Monthly or Less)	Frequent (Weekly)	Constant (Every Day)	Seconds	Minutes	Hours	Days	Weeks
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y ☐ N ☐ Motor vehicle accident
Y ☐ N ☐ Motorcycle accident
Y ☐ N ☐ Work related accident
Y ☐ N ☐ Fall
Y ☐ N ☐ Accident
Y ☐ N ☐ Illness
Y ☐ N ☐ Playground incident
Y ☐ N ☐ Athletic endeavor
Y ☐ N ☐ Fight
Y ☐ N ☐ Injury
Y ☐ N ☐ Unknown
Y ☐ N ☐ _____

If accident, what was the date? _____

What other information is important to your pain or condition? _____

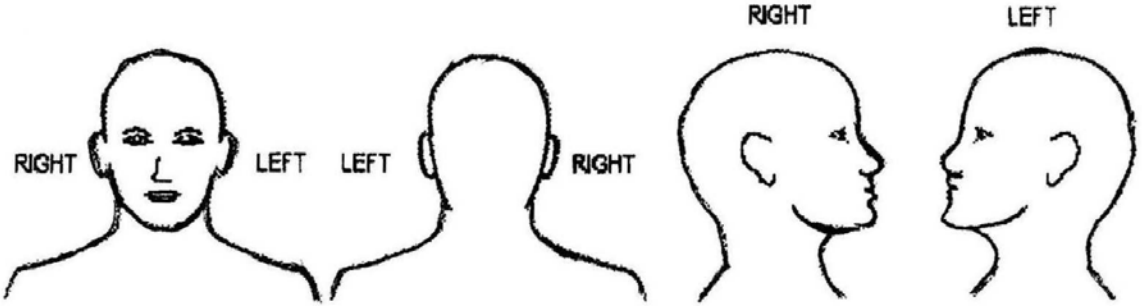
_____

DRAW YOUR PAIN PATTERNS FOLLOWING THE KEY AT THE BOTTOM:

Mild Pain IIIIIIIII

Moderate Pain /\/\/\

Severe Pain //////



B=Burning, D=Dull, N=Numbing, P=Pressure, S=Sharp, T=Tingling, R=Radiating

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____

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SNORING – SLEEP AND APNEA HISTORY

Yes	No	
❑	❑	Do you become easily fatigued? At what time of day? _____
❑	❑	Do you have problems with insomnia? _____
❑	❑	Do you sleep well? How long? _____
❑	❑	On waking up – given an opportunity, could you sleep for another hour or two? _____
❑	❑	Do you dream? How often? _____
❑	❑	Do you have trouble falling asleep or staying asleep? Which? _____
❑	❑	Do you snore or have you been told you do?
❑	❑	Do you wake-up with a headache?
❑	❑	Have you had chronic sleepiness, fatigue or weariness that you cannot explain?
❑	❑	Do you often fall asleep reading or watching TV?
❑	❑	Have you fallen asleep during the day against your will?
❑	❑	Have you had to pull off the road while driving due to sleepiness?
❑	❑	Have you been more irritable and short-tempered?
❑	❑	Have you felt that your memory and/or intellect is impaired?
❑	❑	Have you been told that you stop breathing while asleep?
❑	❑	Do you have difficulty breathing through your nose?
❑	❑	Have any immediate family members been diagnosed or treated for sleep disorder?
❑	❑	Have any family members been diagnosed with heart disease, high blood pressure or diabetes?
❑	❑	Do you smoke? How many? _____
❑	❑	How often do you consume alcohol within 2-3 hours of bedtime?
❑	❑	How often do you consume caffeine within 2-3 hours of bedtime?
❑	❑	Do you wake up at night? How many times? _____
❑	❑	Have you had any other therapy for breathing disorder? Wt. Loss / Surgery / Smoking Cessation
❑	❑	Have you ever had an evaluation at a sleep center

Sleep Center Name: _____

Location: _____

Sleep Study Date: _____

1. When did your symptoms first start?

_____

_____

2. Was there a specific incident, accident or injury that seemed to trigger your symptoms?

3. Do your present symptoms effect your relationships with family & friends? If so, how?

4. What are your expectations in seeking treatment at this time?

5. What do you see yourself doing after treatment that you are not able to do now?

Patient Weight: _____ Patient Neck Circumference: _____
Patient Height: _____ Patient Waist: _____
Normal time to go to bed: _____ Normal wake up time: _____
Number of hrs. of sleep: _____ Quality of sleep (Good/Fair/Poor): _____

CHILDREN - SLEEP HISTORY

Does your child:

- ❑ snore, stops breathing or gasps for air?
- ❑ a restless sleeper?
- ❑ grind teeth at night?
- ❑ wet the bed?
- ❑ breath more through mouth?
- ❑ have allergies?
- ❑ get a lot of sore throats?
- ❑ get a lot of ear infections?
- ❑ have ear tubes placed or recommended to be placed?
- ❑ have had tonsils removed?
- ❑ have had adenoids removed?
- ❑ take any ADD or ADHD medications?

I certify that the above information is correct to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

HOW SLEEPY ARE YOU ??

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired.

Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

Check the box corresponding to your situation.

Situation	Chance of Dozing			
	0 **No** Chance of dozing	**1** **Slight** chance of dozing	**2** **Moderate** chance of dozing	**3** **High** chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g., a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
Totals (for office use only)				

What are the chief complaints for which you are seeking treatment ?

Please **NUMBER** the complaints with #1 being the primary reason for seeking treatment.

_____ Frequent heavy snoring
_____ Snoring which effects the sleep of others
_____ Significant daytime drowsiness
_____ I have been told, “I stop breathing” when sleeping
_____ Gasping when waking up
_____ Nighttime chocking spells
_____ Feeling unrefreshed in the morning
_____ Morning Hoarseness
_____ Morning Headaches
_____ Swelling in ankles or feet
_____ Nocturnal teeth grinding

I certify that the above information is correct to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION

CPAP HISTORY:

YES NO Do you wear a CPAP device successfully during sleeping?
How many hours per night do you wear your CPAP? _____

YES NO Have you tried other therapies for your sleeping disorder?

Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.)

_____

If you are unable to wear a CPAP device, please check below reasons for your difficulty.

- ☐ Mask Leaks
- ☐ Mask Uncomfortable/Device Uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs my sleep and/or bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex Allergy
- ☐ Claustrophobia
- ☐ Other_____

I certify that the above information is correct to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY **Sleep Study Date:** _____

The evaluation confirmed a diagnosis of
- ☐ Mild
- ☐ Moderate Obstructive sleep apnea
- ☐ Severe

The evaluation showed

		during REM	Supine	Side
an RDI of	_____	_____	_____	_____
an AHI of	_____	_____	_____	_____

A nadir SpO2 of _____ T90 _____

Slow Wave Sleep ☐ Decreased ☐ None
REM Sleep ☐ Decreased ☐ None

BED PARTNER SURVEY

Give to bed partner

To help with a proper diagnosis and appropriate treatment plan, have your bed partner, if applicable and available, fill out this questionnaire regarding YOUR sleep habits. This information is vitally important for Dr. Parmar to best evaluate your current conditions.

TO BE FILLED OUT BY THE PATIENT'S **BED PARTNER**

Patient's Name: _____

	Yes	No
Do you witness the patient snoring ?		
Do you witness the patient choking or gasping for breath during sleep ?		
Does the patient pause or stop breathing during sleep ?		
Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours) ?		
Does the patient appear refreshed upon waking ?		
Do the patient's sleep habits disturb your sleep ?		
Does the patient sit up in bed, not awake ?		

Please check those sleep habits of the patient that are disturbing to you:

- ☐ Snores
- ☐ Wakes up often
- ☐ Stops breathing
- ☐ Becoming very rigid or shaking
- ☐ Kicking during sleep
- ☐ Bed-wetting
- ☐ Sleep talking
- ☐ Restless
- ☐ Loud gasping for breath while sleeping
- ☐ Grinds teeth
- ☐ Biting tongue
- ☐ Head rocking or banging
- ☐ Sleep walking
- ☐ Other _____

Comments: _____

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired ?

This refers to daily life in recent times. If these things have not occurred recently, try to work out how they would have affected your partner.

Use the following scale and choose the most appropriate number for each situation.

Situation	**Chance of Dozing**			
	0 **No** Chance of dozing	**1** **Slight** chance of dozing	**2** **Moderate** chance of dozing	**3** **High** chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g., a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
Totals (for office use only)				

Additional Comments regarding the patient's sleep habits not mentioned above: _____

Please sign and date the bottom of this form and many thanks for your help.

Partner's Signature _____ Date _____

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. *Please initial* if you want us to send them a report from your visit.

Initial **FAMILY PHYSICIAN**

Name _____
Address _____
_____
Phone _____

Initial **DENTIST**

Name _____
Address _____
_____
Phone _____

Initial **CHIROPRACTOR**

Name _____
Address _____
_____
Phone _____

Initial **PHYSICAL THERAPIST**

Name _____
Address _____
_____
Phone _____

Initial **ENT**

Name _____
Address _____
_____
Phone _____

Initial **CARDIOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial **ALLERGIST**

Name _____
Address _____
_____
Phone _____

Initial **NEUROLOGIST**

Name _____
Address _____
_____
Phone _____

Initial **PSYCHIATRIST**

Name _____
Address _____
_____
Phone _____

Initial **PSYCHOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial **PULMONOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial **OTHER**

Name _____
Address _____
_____
Phone _____

☐ **I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.**

☐ **I do not wish to have my records sent at this time.**

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

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CONSENT AND RELEASES

Patient Name: _____

Initial

_____ I hereby authorize Dr. Rashmi Parmar and/or her staff to take X-rays, impressions, photographs, slides, and/or videos of my face, jaws and teeth. I understand that the X-rays, impressions, photographs, slides and/or videos can and will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures and demonstrations by Dr. Parmar and/or her staff.

_____ I hereby give permission to have my testimonials and/or X-rays, impressions, photos, slides and videos utilized by Dr. Parmar and/or her staff for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand that I will receive no financial compensation for their use, at anytime, now or in the future, of my testimonials, photos, slides and/or videos by Dr. Parmar and her staff.

_____ I understand that responsibility for payment of dental services provided by this office for myself or my dependent(s) is solely mine, with full payment due and payable at the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including but limited to, non sufficient funds fees, court costs and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

_____ I understand that all services are NOT rendered on the basis that the Insurance Company will pay all of Dr. Parmar's and/or her office fees. Most Insurance Companies may pay only a portion of the services provided. We will be happy to file the necessary forms to see that you receive full benefits of your coverage, however, we make no guarantee of any estimated coverage. We will file primary Insurance. Patients are responsible for filing any secondary insurance coverage they may have.

_____ I understand that I must provide a 48 hours advance notice for cancellations of any of my appointments in order to avoid the imposition of cancellation fees, which are determined by the length and type of services being rendered at that scheduled visit. Such cancellation fees are non-refundable and can range from $50 to $400.

_____ I understand that Dr. Parmar and/or her staff make every effort to see the patients on time, however, emergencies and/or other situations do arise that may sometimes lead to added wait time. I also understand that my appointment has some leeway built into it so that my procedure will be completed.

_____ I authorize Dr. Parmar and/or her staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents involves a certain risk. Furthermore, I authorize and consent that Dr. Parmar and/or her staff choose and employ such assistance as deemed fit to provide recommended treatment.

_____ In case of the need to transfer records, I understand that it will require five working days to duplicate the records. A reasonable record duplication and transfer fee charge will be collected prior to any record transfer.

I have read and understood this entire agreement before initializing and signing and have done it voluntarily without duress and of my own free will and choice.

Patient/Parent/Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to discuss my health information face to face, over the phone, or in writing to:

_____ _____
Name: Relationship Name: Relationship

_____ _____
Name: Relationship Name: Relationship

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: