MASTERPIECE DENTAL STUDIO

The art of optimum-quality dentistry.

HIGH QUALITY DENTAL CARE

- Thorough exams
- Gentle cleanings
- Nonsurgical gum care
- Tooth whitening
- Dental implants
- Full and partial dentures
- Denture relines and repairs
- Crowns and bridges
- Bonding and veneers
- Tooth-colored fillings
- Extractions
- Root canals
- Sealants

AFFORDABLE & CONVENIENT

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- Immediate care if you hurt
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- Most insurance accepted
- Visa and MasterCard honored

Dear New Patient,

Welcome to the Masterpiece family! When it comes to decisions like these, we know there is no shortage of dentists to choose from, and we are thrilled you selected our office to care for all of your dental needs. Whether it's a scheduled appointment, an emergency visit, or a general phone call, you can be confident you will receive the highest quality care and attention at Masterpiece Dental Studio.

Our staff is here to provide long-term dental care to make sure you leave every appointment with a healthier smile. Generally, your first visit will include a thorough examination, x-rays for a proper diagnosis if necessary, and a consultation to clarify your dental needs. Treatment costs and financial responsibilities are determined on a patient-to-patient basis--we will work together to discuss and develop a treatment plan that works for you.

To ensure that your experience at Masterpiece Dental Studio is as comfortable as possible, we ask that you please complete both sides of the enclosed patient registration forms and bring them with you ten minutes before your scheduled appointment. Additionally, if you are covered by dental insurance, please bring your dental insurance card, as well, so that your claims are processed in a timely manner.

Should you have any questions, please feel free to call at your convenience (352-628-0012). Our team is looking forward to meeting you!

Sincerely,

Frank J. Vascimini, D.D.S. and Team

FRANK J. VASCIMINI, DDS

Fellow: Academy of General Dentistry Diplomate: International Congress of Oral Implantology Master: American Academy of Implant Prosthodontics
Member: American Dental Association, American Academy of Cosmetic Dentistry, Florida Academy of General Dentistry, West Coast Dental Association, American College of Oral Implantology, American Society of Osseointegration

4805 SOUTH SUNCOAST BLVD. ■ HOMOSASSA, FL 34446
(352) 628-0012
www.masterpiecedentalstudio.com ■ info@masterpiecedentalstudio.com

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of last Dental visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents ever experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

Is there anything else about having dental treatment you would like to let us know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than ten pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes, _ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE			1
NAME			
SPOUSE			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL PHONE NO.		
EMAIL ADDRESS			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL PHONE NO.		
EMAIL ADDRESS			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE	2
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
YOUR FORMER ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.		EXT.
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.		EXT.

CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use my protected health information to carry out:

- Treatment (including indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I also understand that by signing this consent, I authorize you to use my general information to carry out:

- Calling me to confirm my appointments at the office, remind me to take any necessary medication before an appointment, or to follow up with me after large treatment;
- Mailing out post cards to remind me to schedule my next appointment

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient_____ Date_____

Parent or responsible Party_____ Relationship to Patient_____

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Epworth Sleepiness Scale

Name: _____ Today's Date: _____

Your Age (yrs): _____ Your Sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

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 answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
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 lunch without alcohol	_____
In a car, while stopping for a few minutes in the traffic	_____

THANK YOU FOR YOUR COOPERATION

FRANK J. VASCIMINI, DDS
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Member: American Dental Association, American Academy of Cosmetic Dentistry, Florida Academy of General Dentistry, West Coast Dental Association, American College of Oral Implantology, American Society of Osseointegration

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STOP-BANG QUESTIONNAIRE

Patient Name: _____

Date: _____

1. Have you been told you snore loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes: _____ No: _____

2. Do you often feel tired during the daytime?

   Yes: _____ No: _____

3. Has anyone ever observed you stop breathing while sleeping?

   Yes: _____ No: _____

4. Do you have or are you being treated for high blood pressure?

   Yes: _____ No: _____

5. Height: _____ Weight: _____ BMI Calculation: _____

6. Are you over 50 years old?

   Yes: _____ No: _____

7. Is your neck circumference greater than 16 inches?

   Yes: _____ No: _____

8. Is your gender Male?:

   Yes: _____ No: _____

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