

#### 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

- Early Morning and evening appointments
- Immediate care if you hurt
- Flexible payment
- 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

Patient Name			

Patient Account No.

**DENTAL HISTORY** 

Medical Alert

# 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.

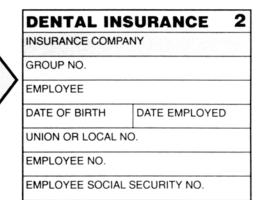
Date of last Dental visit Last D	ental Cl	eaning	Last Full Mouth X-rays		
Previous Dentist's Name					
Address			State Zip _		
Telephone					
How often do you have dental examinations?					
How often do you brush your teeth?			How often do you floss?		
What other dental aids do you use? (Interplak, toothpi	ck, etc.)				
Do you have any dental problems now?	Yes	No			
f yes, please describe:					
Are any of your teeth sensitive to:			Have you ever had:		
Hot or Cold?	Yes	No	Orthodontic treatment?	Yes	N
Sweets?	Yes	No	Oral Surgery?	Yes	N
Biting or Chewing	Yes	No	Periodontal treatment?	Yes	Ν
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	N
Do you frequently get cold sores, blisters,	Voc	No.	A bite plate or mouth guard?	Yes	N
or any other oral lesions?	Yes	No	A serious injury to the mouth or head?  If so, please describe, including cause	Yes	N
Do your gums bleed or hurt?	Yes	No			
Have your parents ever experienced gum disease					
or tooth loss?	Yes	No	Have you experienced:	.,	
Have you noticed any loose teeth or change	Voc	No	Clicking or popping of the jaw?	Yes	N
in your bite?  Does food tend to become caught in between	Yes	No	Pain? (joint, ear, side of face) Difficulty in opening or closing the mouth?	Yes Yes	No No
your teeth?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	N
If yes, where?			Headaches, neckaches or shoulder aches?	Yes	N
, , , , , , , , , , , , , , , , , , , ,			Sore muscles (neck, shoulders)?	Yes	Ν
Do you:					
Clench or grind your teeth while awake or asleep?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	N
Bite your lips or cheeks regularly?	Yes	No	Would you like to keep all of your teeth all of your life?  Do you feel nervous about having dental treatment?	Yes	N
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	If so, what is your biggest concern?	Yes	N
Mouth breathe while awake or asleep?	Yes	No			
Have tired jaws, especially in the morning?	Yes	No	0,		
Smoke/chew tobacco?	Yes	No	Have you ever had an upsetting dental experience? If yes, please describe	Yes	N
is there anything else about having dental treatmen	t voli wo	uld like	e to let us know?	Yes	N

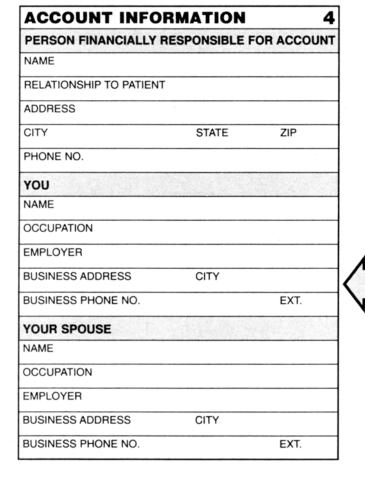
Have you been under the care of a medical doctor during the past two years?   Yes No If yes, for what?   Physician's Name   Phone   Address   City   State   Zip	tient A	lame				MEDICAL	HIST	OF
If yes, for what?		Account No.		Medical Alert				
Physician's Name	1.						Yes	No
Address								
2. Have you taken any medication or drugs during the past two years?  3. Are you taking any medication, drugs or pills now?  If yes, please list name and dosage  4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?  4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?  5. Have you been a patient in the hospital during the past five years?  6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.  6. Heart (Surgery, Disease, Attack)  7. Yes No Ulcers  7. Yes No Hepatitis A (infectious) B (serum)  7. Yes No Chest Pain  7. Yes No Ulcers  7. Yes No Hepatitis A (infectious) B (serum)  7. Yes No Congential Heart Disease  7. Yes No Heart Murmur  7. Yes No Glaucoma  7. Yes No High Blood Pressure  7. Yes No Glaucoma  7. Yes No Blood Transfusion  7. Yes No Artificial Heart Valve  7. Yes No Chronic Cough  7. Yes No Hemphilia  7. Yes No Hemphilia  7. Yes No Hemphilia  7. Yes No Hemphilia  7. Yes No Artificial Heart Valve  7. Yes No Hay Fever  7. Yes No No Hourological Disorders  7. Yes No Sircle Cell Disease  7. Yes No No Hay Fever  7. Yes No No Psychiatric Psychological Care  7. Yes No Doyou use more than two pillows to sleep?  8. Have you lost or gained more than ten pounds in the past year?  9. Do you have or have you had any disease, condition, or problem not listed?  1. Indeest and the above information is necessary to provide me with dental care in a safe and efficient manner.  1. 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.		-						
Are you taking any medication, drugs or pills now?  If yes, please list name and dosage  4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?  5. Have you been a patient in the hospital during the past five years?  6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.  Heart (Surgery, Disease, Attack)		Address	City		;	State Zip		
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If yes, please list:    Have you been a patient in the hospital during the past five years?   Yes No	3.	Are you taking any medication, drugs or	pills now?				Yes	No
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	     	understand the above information in the have answered all questions to the any permission to ask the respective	is necessary to provi best of my knowled health care provider	de me with dental o ge. Should further r or agency, who ma	are ii inforr	n a safe and efficient manne mation be needed, you have	er.	0
Patient/Guardian Signature Date	Р	atient/Guardian Signature				Date		
Date	Diet (Special/Restricted) Artificial Joints (hip, knee, et Kidney Trouble Do you use more than tw Have you lost or gained r Do you have or have you If yes, please list: Women. Are you: Preunderstand the above have answered all query permission to ask th will notify the doctor of	yes ic.) Yes ic.) Yes ic.) Yes o pillows to sle nore than ten p had any disea regnant? Yes, information in stions to the e respective any change	No Radiation Therapy No Chemotherapy No Tumors ep? counds in the past year? se, condition, or problem Months No is necessary to provide the best of my knowled the health care provided in my health or med	Nursing? Yes Note that the control of the control o	No No No care in inforray rei	Fainting or Dizzy Spells Nervous/Anxious Psychiatric/Psychological Care  Taking birth control pills?  In a safe and efficient manner mation be needed, you have lease such information to you	Yes Yes Ner.	No No No No No
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HISTORY REVIEW	١							
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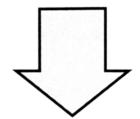
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APPOINTMENT IS FOR YOU	ADDRESS			
START HERE	CITY		STATE	ZIP
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,	EMAIL ADDRES	S		
	BIRTHDATE	AGE	MALE	FEMALE
	MARRIED	SINGLE	DIVORCED	WIDOWED
	SOCIAL SECUR	ITY NO.		
N	DATE			
IF THIS	NAME			
APPOINTMENT IS FOR YOUR CHILD	ADDRESS			
START HERE	CITY		STATE	ZIP
$\neg V$	HOME PHONE I	NO.	CELL PHONE	NO.
,	EMAIL ADDRES	S		
	BIRTHDATE	AGE	MALE	FEMALE
	SCHOOL			GRADE
	SOCIAL SECUR	ITY NO.		
		CHILD'S LAST NA		

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION







	GETTING TO KNO	w you	3
	IS ANOTHER MEMBER OF YOU AT OUR OFFICE?	JR FAMILY OF	RELATIVE A PATIENT
	NAME:	RELATION	SHIP:
	REFERRED TO US BY		
	PERSON TO CONTACT FOR EN	MERGENCY	
	PHONE NUMBER		
1	ADDRESS		
1	CITY	STATE	ZIP
	CLOSEST RELATIVE NOT LIVIN	NG WITH YOU	
	PHONE NUMBER		
	ADDRESS		
	CITY	STATE	ZIP
	YOUR FORMER ADDRESS		
	CITY	STATE	ZIP

#### 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.

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		



#### HIGH QUALITY DENTAL CARE

- Thorough exams
- Gentle cleanings

MasterCard honored

## **Epworth Sleepiness Scale**

	cleanings					
	Nonsurgical gum care	Name:	Today's Date:			
	Tooth whitening	Your Age (yrs): Your Sex (Male =	= M, Female = F):			
	Dental implants	How likely are you to doze off or fall asleep in the				
-	Full and partial dentures	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.				
-	Denture relines and	Use the following scale to choose the most approp	oriate number for e	ach situation:		
	Crowns and bridges	0 = would never 1 = slight chance o	f dozing			
	Bonding and veneers	2 = moderate chance of 3 = high chance of	A			
	Tooth-colored fillings	It is important that you answer each	question as best y	ou can.		
	Extractions Root canals	Situation	Cha	ance of Dozing (0-3)		
	Sealants	Sitting and reading				
A &	FFORDABLE CONVENIENT	Watching TV				
	Early Morning and evening	Sitting, inactive in a public place (e.g. A theater or	a meeting)			
	appointments Immediate	As a passenger in a car for an hour without a break	< <del></del>			
	care if you hurt	Lying down to rest in the afternoon when circumst	ances permit			
	Flexible payment plans	Sitting and talking to someone				
	Most	Sitting quietly after lunch without alcohol				
	insurance accepted	In a car, while stopping for a few minutes in the tra	affic			
	Visa and					

### THANK YOU FOR YOUR COOPERATION

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



## HIGH QUALITY DENTAL CARE

■ Thorough exams

■ Visa and

MasterCard honored

## **STOP-BANG QUESTIONNAIRE**

	Gentle cleanings	<u>Patien</u>	t Name:
88	Nonsurgical gum care	<u>Date</u> :	
	Tooth whitening	1.	Have you been told you snore loudly (louder than talking or loud enough to be
	Dental implants		heard through closed doors)?
	Full and partial dentures		Yes: No:
	Denture relines and repairs	2.	Do you often feel tired during the daytime?
	Crowns and bridges		Yes: No:
H	Bonding and veneers	3.	Has anyone ever observed you stop breathing while sleeping?
	Tooth-colored fillings		Yes: No:
	Extractions Root canals	4.	Do you have or are you being treated for high blood pressure?
	Sealants		Yes: No:
A &	FFORDABLE CONVENIENT	5.	Height: BMI Calculation:
	Early Morning and evening appointments	6.	Are you over 50 years old?
=	Immediate care if you		Yes: No:
	Flexible payment	7.	Is your neck circumference greater than 16 inches?
	plans Most		Yes: No:
	insurance accepted	8.	Is your gender Male?:

#### THANK YOU FOR YOUR COOPERATION

Yes: \_\_\_\_\_ No: \_\_\_\_

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