NELSON R. DIERS, D.D.S., INC.
Orthodontics, TMJ & Sleep Treatment

FAIRFILED
1251 Nilles Rd #14,
Fairfield, OH 45014
(513) 829-4400

COLERAIN
3020 Banning Road
Cincinnati, OH 45239
(513) 923-1800

LIBERTY TOWNSHIP
7218 Towne Center Drive
West Chester, OH 45069
(513) 777-9040

Adult New Patient Form

Today's Date _____

Name _____ Birth Date _____

Address _____ Home Phone _____

City & State _____ Zip _____

Employer _____ Business No. _____

Insurance _____ SS# _____

Spouse's Name _____ Employer _____

Insurance _____ SS # _____ Business No. _____

Person Responsible for Account _____

Email Address _____

Dental History

Dentist _____ Last Visit _____

What concern brings you to our office? _____

_____

Is this your 1st orthodontic exam? _____

Has there been an injury to the face, head or neck? _____

If yes, please explain _____

Do you hear popping or clicking noises in your jaws when you chew? _____

List names of family members in treatment at our office _____

_____

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

I understand that due to the nature and length of much orthodontic treatment, payment is often arranged over a period of time. Therefore, I authorize Dr. Diers' office to obtain a credit report from the Credit Bureau of Cincinnati.

Date _____ Signature _____

Dental History

1. YES ☐ NO ☐ ..... Permanent or extra (supernumerary) teeth removed?
2. YES ☐ NO☐ ..... Supernumerary (extra) or congenitally missing teeth?
3. YES ☐ NO ☐ ..... Chipped or injured primary or permanent teeth?
4. YES ☐ NO ☐ ..... Any sensitive or sore teeth?
5. YES ☐ NO ☐ ..... Bleeding gums, bad taste or mouth odor?
6. YES ☐ NO ☐ ..... Jaw fractures, cysts, infections?
7. YES ☐ NO ☐ ..... Any teeth treated with root canals or pulpotomies?
8. YES ☐ NO ☐ ..... Frequent canker sores or cold sores?
9. YES ☐ NO☐ ..... History of speech problems or speech therapy?
10. YES ☐ NO ☐ ..... Difficulty breathing through nose?
11. YES ☐ NO ☐ ..... Food impaction between teeth?
12. YES ☐ NO ☐ ..... Mouth breathing habit or snoring at night?
13. YES ☐ NO ☐ ..... Frequent oral habits(sucking finger, chewing pen, etc.)?
14. YES ☐ NO ☐ ..... Teeth causing irritation to lip, cheek or gums?
15. YES ☐ NO ☐ ..... Abnormal swallowing (tongue thrust)?
16. YES ☐ NO ☐ ..... Tooth grinding or clenching?
17. YES ☐ NO ☐ ..... Clicking, locking in jaw joints?
18. YES ☐ NO ☐ ..... Soreness in jaw muscles or face muscles?
19. YES ☐ NO ☐ ..... Ringing in ears, difficulty in chewing or opening jaw?
20. YES ☐ NO ☐ ..... Have you ever been treated for “TMJ” or “TMD” problems?
21. YES ☐ NO ☐ ..... Any broken or missing fillings?
22. YES ☐NO ☐ ..... Any serious trouble associated with previous dental treatment?
23. YES ☐ NO ☐ ..... Have you ever been diagnosed with gum disease or pyorrhea?

Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○YES ○NO If yes _____

Have you ever been hospitalized or had a major operation? ○YES ○NO If yes _____

Have you ever had a serious head or neck injury? ○YES ○NO If yes _____

Are you taking any medication pills or drugs? ○YES ○NO If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ○YES ○NO If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphates? ○YES ○NO If yes _____

Are you on a special diet? ○YES ○NO

Do you use tobacco? ○YES ○NO

Do you use controlled substances? ○YES ○NO If yes _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptive

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codein ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? If yes _____

Do you have any of the following?

AIDS/HIV Positive ○YES ○NO	Cortisone Medicine ○YES ○NO	Hemophilia ○YES ○NO	Radiation Treatments ○YES ○NO
Alzheimer's Disease ○YES ○NO	Diabetes ○YES ○NO	Hepatitis A ○YES ○NO	Recent Weight Loss ○YES ○NO
Anaphylaxis ○YES ○NO	Drug Addiction ○YES ○NO	Hepatitis B or C ○YES ○NO	Renal Dialysis ○YES ○NO
Anemia ○YES ○NO	Easily Winded ○YES ○NO	Herpes ○YES ○NO	Rheumatic Fever ○YES ○NO
Angina ○YES ○NO	Emphysema ○YES ○NO	High Blood Pressure ○YES ○NO	Rheumatism ○YES ○NO
Arthritis/Gout ○YES ○NO	Epilepsy or Seizures ○YES ○NO	High Cholesterol ○YES ○NO	Scarlet Fever ○YES ○NO
Artificial Heart Valve ○YES ○NO	Excessive Bleeding ○YES ○NO	Hives and Rash ○YES ○NO	Shingles ○YES ○NO
Artificial Joint ○YES ○NO	Excessive Thirst ○YES ○NO	Hypoglycemia ○YES ○NO	Sickle Cell Disease ○YES ○NO
Asthma ○YES ○NO	Fainting Spells/Dizziness ○YES ○NO	Irregular Heartbeat ○YES ○NO	Sinus Trouble ○YES ○NO
Blood Disease ○YES ○NO	Frequent Cough ○YES ○NO	Kidney Problems ○YES ○NO	Spina Bifida ○YES ○NO
Blood Transfusion ○YES ○NO	Frequent Diarrhea ○YES ○NO	Leukemia ○YES ○NO	Stomach/Intestinal Disease ○YES ○NO
Breathing Problems ○YES ○NO	Frequent Headaches ○YES ○NO	Liver Disease ○YES ○NO	Stroke ○YES ○NO
Bruise Easily ○YES ○NO	Genital Herpes ○YES ○NO	Low Blood Pressure ○YES ○NO	Swelling of Limbs ○YES ○NO
Cancer ○YES ○NO	Glaucoma ○YES ○NO	Lung Disease ○YES ○NO	Thyroid Disease ○YES ○NO
Chemotherapy ○YES ○NO	Hay Fever ○YES ○NO	Mitral Valve Prolapse ○YES ○NO	Tonsillitis ○YES ○NO
Chest Pains ○YES ○NO	Heart Attack/Failure ○YES ○NO	Osteoporosis ○YES ○NO	Tuberculosis ○YES ○NO
Congenital Heart Disorder ○YES ○NO	Heart Murmur ○YES ○NO	Parathyroid Disease ○YES ○NO	Tumors or Growth ○YES ○NO
Convulsions ○YES ○NO	Heart Pacemaker ○YES ○NO	Psychiatric Care ○YES ○NO	Ulcers ○YES ○NO
ADHD ○YES ○NO	Heart Trouble/Disease ○YES ○NO	Anxeity ○YES ○NO	Venereal Disease ○YES ○NO
Acid Reflux ○YES ○NO	Migraines ○YES ○NO	Depression ○YES ○NO	Yellow Jaundice ○YES ○NO
Sleep Apnea ○YES ○NO	Use of CPAP ○YES ○NO	Developmental Delay ○YES ○NO	Sensory Disorders ○YES ○NO

Have you ever had any serious illness not listed above? ○YES ○NO If yes _____

Comment: _____

Signature of patient, parent or guardian: _____ Date: _____

Epworth Sleep Questionnaire

Questionnaire Used to Identify Sleep Disorder Candidates

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

Please list any medical problems withing the last 5 years (hypertension, diabetes, surgery, etc.)

_____

_____

Have you suffered a heart attack or stroke? _____ When? _____

Select the appropriate response:

1. Do you snore at night? ..... YES ◯ NO ◯ Occasionally ◯
2. Witness pauses in breathing while asleep? ..... YES ◯ NO ◯ Occasionally ◯
3. Do you have difficulty falling asleep? ..... YES ◯ NO ◯ Occasionally ◯
4. Do you have difficulty maintaining sleep? ..... YES ◯ NO ◯ Occasionally ◯
5. Experience a restless sensation in legs while laying awake? ..... YES ◯ NO ◯ Occasionally ◯
6. Kicking and teitching movements while asleep? ..... YES ◯ NO ◯ Occasionally ◯
7. Experience excessive daytime tiredness? ..... YES ◯ NO ◯ Occasionally ◯
8. Have you ever awakened feeling paralyzed? ..... YES ◯ NO ◯ Occasionally ◯
9. Experience a sdden loss of strength in your arms or legs? ..... YES ◯ NO ◯ Occasionally ◯
10. If the previous answer is Yes, were these events brought on by a sudden, frightening event or laughter?

..... YES ◯ NO ◯

Select all that apply:
Do you frequently awaken with:

- ☐ dry mouth
- ☐ headache
- ☐ chest pain
- ☐ choking & gasping
- ☐ nasal congestion
- ☐ heartburn
- ☐ excessive sweating
- ☐ feeling groggy & unrefreshed

According to the following scale choose the appropriate number value to represent how likely you are to fall asleep during the day in the following situations. Try to be as honest as possible. If possible have your significant other help you fill this out.

0 - never 1 - slight chance 2 - moderate 3 - always

Sitting and reading	◯ 0	◯ 1	◯ 2	◯ 3
Watching T.V.	◯ 0	◯ 1	◯ 2	◯ 3
Sitting inactive in public (movie theatre, meeting)	◯ 0	◯ 1	◯ 2	◯ 3
Sitting and talking to someone	◯ 0	◯ 1	◯ 2	◯ 3
As a passenger in a car for an hour without a break	◯ 0	◯ 1	◯ 2	◯ 3
Driving a vehicle for two or more hours	◯ 0	◯ 1	◯ 2	◯ 3
Lying down to rest in afternoon when circumtances permit	◯ 0	◯ 1	◯ 2	◯ 3

Total: _____

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Acknowledgement of Receipt of Statement of Privacy Policy

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Nelson R. Diers, D.D.S. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Nelson R. Diers, D.D.S. reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES ☐ NO ☐
SPOUSE ONLY	YES ☐ NO ☐
OTHER (Please Specify):	YES ☐ NO ☐

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained		
PROVIDED PRIOR TO TREATMENT? YES ☐ NO ☐		
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICE
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING
	☐	UNABLE TO SIGN
	☐	REASON NOT GIVEN
	☐	OTHER (EXPLAIN):

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Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Ohio. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentially of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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