KENT LANE MUELLER, D.D.S.

1115 N. Easton Road
Willow Grove, Pennsylvania 19090
215-657-5700 Fax 215-657-5717
www.kmuellerdds.com

*Today's date*_____

(The information requested is necessary for our files and your health, and will be considered confidential)

*Name*_____*Age*_____*Spouse's Name*_____

*Residence Address*_____*City*_____*State*_____*Zip*_____

< > married < > single < > divorced < > separated < > widowed < > engaged

*Social Security #*_____*Your Date of Birth* _____*Home Phone #*_____

*E-mail address*_____ *Cell Phone #*_____

*Employed By*_____*Occupation*_____

*Business Address*_____*Business Phone #*_____

*Spouse Employed By*_____*Occupation*_____

*Business Address*_____*Business Phone #*_____

*Name of Your Physician*_____*Address*_____*Physician Phone #*_____

*Name of Your Former Dentist*_____*Address*_____*Dentist Phone #*_____

*Whom may I thank for referring you to my office?*_____

*Who is the person financially responsible for this account?*_____

*If you are completing this form for another person, what is your relationship to that person?*_____

DENTAL 'INSURANCE' INFORMATION:

Do you have dental 'insurance'? *< > Yes < > No*
If yes, are you familiar with your plan's benefits, restrictions, and limitations? *< > Yes < > No*
If married, does your spouse have dental 'insurance' that benefits you also? *< > Yes < > No*

*Name of Your Dental 'Insurance' Carrier*_____

*Name of Group Dental Plan*_____*Group #*_____

*Insured Employee*_____ *Employee's ID #*_____ *Patient's Relationship to Employee* *< > Self < > Spouse < > Child*

YOUR MEDICAL HEALTH INFORMATION: ***(please circle)***

Are you in good health? ……. *Yes No*
Has there been any change in your general health within the past year? ……. *Yes No*
Are you now under the care of a physician or specialist? ……. *Yes No*
If yes, for what condition are you receiving care or testing? _____
Have you had any serious illness or operation? ……. *Yes No*
If yes, please describe _____
Have you been hospitalized or had a serious illness within the past 5 years? ……. *Yes No*
If yes, please describe the incident _____
Do you now have, or have you ever had any of the following diseases or problems?
Rheumatic Fever or Rheumatic Heart Disease ……. *Yes No*
Heart Murmur or Congenital Heart Lesions or Defects ……. *Yes No*
Cardiovascurlar Disease:
Heart Trouble, Heart Attack or Myocardial Infarction (M.I.), Coronary Insufficiency, Coronary Occlusion, High Blood Pressure, Stroke or Transient Ischemic Attack (T.I.A.).……. *Yes No*
Do you have pain in the chest upon exertion? ……. *Yes No*

Do you experience shortness of breath after mild exercise? …… *Yes* *No*
Do your ankles swell? …… *Yes* *No*
Do you get short of breath when you lie down, or do you require extra pillows when you sleep? . *Yes* *No*
Do you have a cardiac pacemaker, or experience arrhythmia (irregular heartbeats)? …… *Yes* *No*

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Do you now have, or have you ever had any of the following diseases or problems? Please note your medications

Allergy …… *Yes* *No*
Sinus problems …… *Yes* *No*
Asthma or Hay Fever …… *Yes* *No*
Hives or a Skin Rash …… *Yes* *No*
Low Blood Pressure, Dizziness …… *Yes* *No*
Fainting Spells or Seizures …… *Yes* *No*
Diabetes …… *Yes* *No*
Do you have to urinate (pass water) more than six times a day? …… *Yes* *No*
Are you thirsty much of the time? …… *Yes* *No*
Does your mouth frequently become dry? …… *Yes* *No*
Hepatitis A, Hepatitis B, Hepatitis C, Jaundice, or Liver Disease …… *Yes* *No*
Arthritis …… *Yes* *No*
Inflammatory Rheumatism (painful swollen joints) …… *Yes* *No*
Stomach Ulcers, Gastric Reflux, Colitis, Hemorrhoids, Gastric or Intestinal bleeding, blood in stools *Yes* *No*
Eating Disorders such as Bulimia or Anorexia …… *Yes* *No*
Kidney problems, or blood in the urine …… *Yes* *No*
Tuberculosis (TB) …… *Yes* *No*
Persistent Cough, or coughing up blood …… *Yes* *No*
Do you have any Blood Disorder (e.g. anemia, leukemia…etc.)? …… *Yes* *No*
Have you had Abnormal Bleeding associated with previous dental extractions, surgery, or traumatic incident? *Yes* *No*
Do you have genetic 'Clotting Factor' deficiency that would affect normal blood clotting times? …… *Yes* *No*
Do you bruise easily? …… *Yes* *No*
Have you ever required a Blood Transfusion? …… *Yes* *No*
If yes, please describe the circumstances _____
Have you had surgery, or radiation treatment, or chemotherapy in treatment of a tumor, growth, cancer, or other condition involving your head and neck? …… *Yes* *No*
Are you currently diagnosed or in treatment for any neoplasm, malignancy or cancer, blood dyscrasia,…etc. *Yes* *No*
Are you 'test positive' for Human Immunodeficiency Virus (HIV), or Aquired Immuno-deficiency Disease (AIDS)? *Yes* *No*
Do you have reason to believe you may 'test positive' in the near future due to previous exposure? *Yes* *No*
*Are you **now taking** any Drugs or Medicines at this time?* …… *Yes* *No*
Are you taking any of the following:
Antibiotics or sulfa drugs …… *Yes* *No*
Anticoagulants or 'blood thinners' …… *Yes* *No*
Aspirin, Advil, Tylenol, or other over-the-counter pain medications …… *Yes* *No*
Prescription Pain Medications …… *Yes* *No*
High Blood Pressure medications …… *Yes* *No*
Cortisone, Prednisone, or other Steroids …… *Yes* *No*
N-S anti-inflammatory pain medications (e.g. Celebrex, Nuprin, Motrin). …… *Yes* *No*
Tranquilizers, Anti-Depressants, (e.g. Valium, Zoloft, Prozac,…etc.) …… *Yes* *No*
Antihistamines …… *Yes* *No*
Insulin, tolbutamide (Orinase) or similar medication …… *Yes* *No*
Digitalis, or medication for heart condition …… *Yes* *No*
Nitroglycerin …… *Yes* *No*
Immunosuppressant medications …… *Yes* *No*
Oral Contraceptives or other Hormonal Medications …… *Yes* *No*
Other Medications not listed above …… *Yes* *No*

*Are you **allergic to**, or have you reacted adversely to any of the following Drugs or Medications?*

Local Anesthetics such as 'Novocaine" …… *Yes* *No*
Antibiotics such as Penicillin, Erythromycin, Keflex, etc. …… *Yes* *No*
Sulfa Drugs …… *Yes* *No*
Sulfite preservatives (placed in some medicaments) …… *Yes* *No*
Barbiturates, sedatives, or sleeping pills …… *Yes* *No*
Aspirin, Advil, Nuprin, Vioxx, Motrin,N-S anti-inflammatory meds, etc. …… *Yes* *No*
Iodine …… *Yes* *No*
Codeine or other Narcotic medications …… *Yes* *No*
Other Medications not listed above …… *Yes* *No*

Are you at this time drug dependent, or have you ever had in the past an addictive drug or medication dependence on pain medications, codeine products, narcotics,…etc. ? …… *Yes* *No*
Do you wear contact lenses? …… *Yes* *No*

(Women) Are you pregnant at this time? …… *Yes* *No*
(Women) Do you have any problems associated with your menstrual period? …… *Yes* *No*
Have you been advised to by your Primary Physician, Cardiologist, Orthopedic Surgeon, et.al. that you must take an antibiotic prior to receiving care in the Dental Office? …… *Yes* *No*

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YOUR DENTAL HEALTH INFORMATION:

Tell me what is your immediate Dental Concern?_____
Are you presently experiencing Dental Pain? …… *Yes* *No*
If yes, please describe: _____
When was your last dental examination? _____
When did you last receive dental treatment? _____
Have you ever had any serious trouble associated with any previous dental treatment? …… *Yes* *No*
Do you feel dissatisfied or self-conscious about your teeth? …… *Yes* *No*
If yes, please explain why: _____
Does dental treatment make you nervous or anxious? …… *Yes* *No*
If yes, please circle: *Slightly* *Moderately* *Extremely*
Have you lost any teeth? …… *Yes* *No*
If yes, please describe the cause:
Have you had your teeth straightened (Orthodontics)? …… *Yes* *No*
If yes, please state when and by whom: _____
Have you had any gum treatment other than routine cleanings? …… *Yes* *No*
Have you ever been told your have 'periodontal disease' or 'pyorrhea' by another dentist? …… *Yes* *No*
Are you aware of a parent or sibling losing teeth to periodontal disease (gum disease)? …… *Yes* *No*
Have you experienced any of the following problems?
Bleeding gums …… *Yes* *No*
Receding of the gums exposing tooth roots …… *Yes* *No*
Swelling , lumps, or ulcers in the gums, mouth or neck area …… *Yes* *No*
Difficulty swallowing …… *Yes* *No*
Mobile or loose teeth …… *Yes* *No*
Shifted or drifting teeth …… *Yes* *No*
Food wedging between your teeth …… *Yes* *No*
Bad breath …… *Yes* *No*
Unpleasant taste …… *Yes* *No*
Sensitivity to cold, heat, sweets, or pressure …… *Yes* *No*
Have you ever been diagnosed or treated for TMJ pain (Temporo-Mandibular-Joint-Dysfunction-Syndrome)? . *Yes* *No*
Have you ever experienced the following symptoms?
Pain around the ear with eating or jaw movements …… *Yes* *No*
'Cracking' or 'Clicking' or 'Crunching' sounds in the jaw joint area upon opening and closing the jaws *Yes* *No*
Limitation or restriction of jaw movements …… *Yes* *No*
Clenching or grinding your teeth …… *Yes* *No*
Grooving of exposed tooth roots …… *Yes* *No*
Fracturing of tooth fragments …… *Yes* *No*
Sharp pain in individual teeth with strong closure …… *Yes* *No*
Muscle soreness associated with the jaws upon wakening from sleep …… *Yes* *No*
Unexplained recurrent head aches, migraines, neck or shoulder pain …… *Yes* *No*
Do you wear a night guard or bite guard to keep you from grinding your teeth? …… *Yes* *No*
Do you feel your teeth are wearing or eroding away? …… *Yes* *No*
Have you ever had a localized or full mouth 'occlusal adjustment' or 'equilibration' (bite adjustment) …… *Yes* *No*
Do you wear a denture to replace teeth that you have lost? …… *Yes* *No*
If yes, are you comfortable with how your denture feels in your mouth with regard to fit, appearance, stability, taste, and function (ability to chew food)? …… *Yes* *No*
If yes, are you comfortable with the cosmetic support your prosthesis gives to the muscles and soft tissues of the lips and cheeks? …… *Yes* *No*
Do you Snore when sleeping? …… *Yes* *No*
Have you ever been diagnosed as having 'Sleep Apnea'? …… *Yes* *No*
Have you had Dental Implants placed to restore lost teeth or retain a loose denture? …… *Yes* *No*
Do you drink soda and energy drinks? How many do you?..... *Yes* *No*
Do you smoke or chew tobacco products? …… *Yes* *No*
If yes, please circle: *cigarettes* *pipe* *cigar* *chewing tobacco*
Have you smoked in the past? When did you quit? CONGRATS!..... *Yes* *No*
Do you use the following?
Toothbrush (please circle): *hard bristle* *medium bristle* *soft bristle* …… *Yes* *No*
If yes, how often and when do you brush? _____
Dental Floss …… *Yes* *No*
If yes, how often do you floss? _____
Other Hygiene Aids such as oral rinses, water-pik, electric tooth brush…etc. …… *Yes* *No*

If yes, please list _____

Do you want to learn to control your dental disease and retain your teeth?

Do you feel you would spend 5 minutes per day taking proper care of your teeth?

Please describe any current medical treatment, dental treatment, or impending operations, test, or surgeries, or any other medical or dental information that may possibly affect your dental diagnosis and treatment:

_____

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HOW DID YOU COME TO CHOOSE DR. MUELLER'S OFFICE TO RECEIVE YOUR DENTAL CARE?

(Please check most appropriate responses)

< > *I am interested in becoming a 'Sleep Dentistry' patient to receive my total care under I.V. Sedation for reasons checked:*
- < > *Anxious, Fearful, or Dental Phobic*
- < > *Time constraints and overwhelming treatment requirements*
- < > *Anesthetic Reactions*
  - *Unable to get 'numb' with local anesthetic injections*
  - *Allergic sensitivity to local anesthetics*
- < > *Physical or Mental Disabilities*
- < > *Gag reflex*
- < > *Difficulty breathing while holding mouth open for treatment*
- < > *Difficulty in tolerating the dental treatment environment, e.g. agoraphobia, physical handicap, claustrophobia, etc.*

< > *I am aware of Dr. Mueller's educational credentials, General Practice Residency, Graduate and Post-Graduate studies*

< > *I am interested in Dr. Mueller's work with Dental Implants to replace lost natural teeth, or stabilize a denture. I am aware that Dr. Mueller will surgically place dental implants as well as construct the prosthetic dentition they will support*

< > *I am aware this is a 'Mercury – free' dental office*

< > *I am interested in Dr. Mueller's work with TMJ and occlusion (bite)*

< > *I am interested in an 'Artistic Smile Design' treatment plan to enhance my overall facial appearance*

< > *I am interested in the replacement of existing dental restorations, or aging prosthetic crowns and bridges*

< > *I am interested in Dr. Mueller's work in treating gum disease and strengthening existing bone and gum oral tissues*

< > *I am aware that I am in need of a 'full mouth dental reconstruction'*

I was referred to Dr. Mueller for general care by:
- < > *My family physician*
- < > *My previous dentist*
- < > *An acquaintance or relative who is a current patient of Dr. Mueller*
- < > *Yellow Pages advertisement*
- < > *A 'flyer' or newspaper announcement*
- < > *Dental Implant Society*
- < > *PPO 'insurance' directory listing*
- < > *Internet Web Site www.sleepdentistry-mueller.com*

TELL US HOW YOU WISH TO RECEIVE TREATMENT IN THIS OFFICE:

(Please check most appropriate descriptions)

< > *I am here for treatment of an immediate problem or emergency only*

< > *I am here for a cosmetic consultation only*

< > *I will consent to treatment, only if my dental 'insurance' plan will pay for it*

< > *I am here for a second opinion at this time only*

< > *I am here for a specific procedure only (e.g. 'snore guard', athletic mouth guard, full mouth bleaching, etc…)*

< > *I am interested in a comprehensive treatment plan that will be to my best long-term health advantage, regardless of the restrictions and limitations placed on me by my 'insurance' plan, and regardless of expense to me*

< > *I am interested in a comprehensive treatment plan; however, I have little familiarity with the procedures and costs involved; I will need some educating in these respects*

< > *I wish you to continue to treat only those teeth that develop pain or fracture*

< > *I wish to consider only those restorative procedures and materials used that are of least expense to me*

< > *I am interested in enhancing my 'smile presentation' only at this time; I will consider fixing the rest of my teeth later*

< > *I expect to maintain an organized Oral Hygiene preventive recall schedule after my treatment plan is completed*

< > *I am interested in receiving a 'level of care' Dr. Mueller would consider most appropriate for himself and his family*

The above statements regarding my medical health history and dental health history are true to the best of my knowledge. I understand that it is my responsibility to keep this information updated with regard to any pertinent changes by informing the Dental Staff or Doctor. I authorize dental treatment to be rendered by Dr. Mueller and his Dental Staff, and I assume financial responsibility for treatment.

Signature _____ *Date* _____

(Parent or guardian if patient is a minor)

KENT LANE MUELLER, D.D.S.

1115 N. EASTON ROAD
WILLOW GROVE, PENNSYLVANIA 19090
215-657-5700 FAX 215-657-5717

Consent for Services

As a condition of your treatment in this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for the payment of all dental services. This office will assist in the preparation and submission of the patient's insurance forms or assist in making collections from insurance companies, and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full or in part by an insurance company. It is the responsibility of the patient to understand the extent of benefit coverage and limitations of his /her insurance plan. This office shall assist in the explanation and determination of plan benefit coverage on behalf of the patient to aid in making reasonable estimates as to benefit coverage for required dental treatment.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value for said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____*Date:* _____*Relationship to Patient:* _____

Signature of patient, parent or guardian

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Kent Lane Mueller, D.D.S.
1115 N. Easton Road
Willow Grove, Pennsylvania 19090
215-657-5700 Fax 215-657-5717

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 operators. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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OFFICE USE ONLY

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

Date:	**Initials:**	**Reason:**

THIS IS A HIPPA FORM