

Personal Information-Health History

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NAME _____ Birthday _____ Social Security # _____

Mailing Address _____ City, State, Zip Code _____

HOW OR WHO REFERRED YOU TO OUR OFFICE? _____

PHONES: Work _____ Home _____ FAX _____

Cell _____ Email _____

OCCUPATION _____ EMPLOYER _____

Dental Insurance: Name of Ins. Company _____ Telephone Number _____

Are you the primary policy holder Yes No If No please enter policy holders information below

SPOUSE'S NAME _____ OCCUPATION/EMPLOYER _____

ACCOUNT RESPONSIBILITY if someone other than yourself: Name _____

Their Social Security No. _____ Birthday _____

Mailing Address _____ Daytime Phone _____

What name would you like us to call you? _____

Please describe the reason for your visit today:

How long has this been going on and what other events apply to today's visit?

Why have you decided to deal with this now?

Have you consulted with any other dentist about this? Yes No If yes, what was discussed or done?

When was your last dental exam? _____

Who is your regular or previous dentist? _____

Would you like us to request records? _____

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____ DATE: _____

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:		YES	NO			YES	NO
1.	hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27.	arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	28.	autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			30.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			31.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			32.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			33.	neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			34.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			35.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			36.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex			37.	STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			38.	hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	39.	HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
12.	prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56.	taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	58.	prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>				
25.	digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>				
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>				

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
6. Have you had any teeth removed or missing teeth that never developed? _____

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench your teeth in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Dallas, Tx 75252

FINANCIAL Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express or Discover at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Missed Appointment

- If you need to reschedule an appointment please notify us as soon as possible. **There will be a \$50.00 fee charged to your account for any appointment missed without prior 24 hour notification.**

Returned Check Fee

- Returned checks will be subject to a \$50.00 charge. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient Signature

Date

Dr. Vicki Borowski, D.D.S.
17300 Preston Road, Suite #100
Dallas, Texas 75252
972-380-6223
www.vickiborowski.com

Authorized Credit Card Payment Form

I authorize Vicki Borowski, DDS to keep my signature on file and to charge my credit card for:

- Balance of charges not paid by insurance within 30 days:
- All visits this year.
- Recurring charges (on-going treatments) of \$_____ every_____ from_____
- (frequency) (date)
- to_____.
(date)

I assign my insurance benefits to the provided listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I also understand that I will be notified monthly or whenever charges are going to be put onto this card.

Patient Name

Cardholder Name

Cardholder Address

City State Zip

Credit Card Account Number Security Code Expiration Date

Cardholder Signature Date

Complaints

Complaints about your privacy rights or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20211

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

Confidential Information Agreement

Please list the family members or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Please list the family members or other persons, if any, with whom we may discuss your dental treatment **ONLY IN AN EMERGENCY.**

_____ Same as above

_____ No one

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Please print the telephone number, if any, where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions.

Telephone Number _____

May confidential messages be left on the answering machine or voicemail number given above?

Yes _____ No _____

If you do not have an answering machine or voicemail, may a confidential message be left with a secretary or personal assistant? Yes _____ No _____

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Dr. Vicki Borowski took before receiving my revocation.

Patient's Signature

Date

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

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:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	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	•

Total Score = _____

Analyze Your Score

Interpretation:

- 0-7:** It is unlikely that you are abnormally sleepy.
- 8-9:** You have an average amount of daytime sleepiness.
- 10-15:** You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
- 16-24:** You are excessively sleepy and should consider seeking medical attention.