NEW PATIENT REGISTRATION FORM **Date:**

The Art of Dentistry & Main Line Snoring Solutions by Stephen Gershberg, 14 S Bryn Mawr Ave Ste. 200, Bryn Mawr PA 19010

Patient Name (Last,First,MI):	**Nickname:**
Date of Birth (DOB): Age:	**Marital Status:**
Street Address:	**Gender**
City/State/Zip:	**Cell Phone:**
Email:	**Home Phone:**
Social Security Number	**Other Phone:**
Employer	**Work Phone:**
Emergency Contact	**Contact Phone:**
Person Financially Responsible for Account (L,F,M):	
Who can we thank for referring you	

INSURANCE INFORMATION: Please note that if your carrier requires Pre-Authorization or Pre-Approval, you are required to obtain prior to your appointment. You may need to check with your carrier if you have a waiting period. Please bring your insurance cards with you to your appointment

Primary Medical Insurance:	**Phone:**
Insurance ID No:	**Insurance Group No:**
Street Address:	**City/State/Zip:**
Subscriber Name (L,F,M): DOB:	**Relation to Patient self/spouse/child/other**
Primary Dental Insurance:	**Phone:**
Insurance ID No:	**Insurance Group No:**
Street Address:	**City/State/Zip:**
Subscriber Name (L,F,M): DOB:	**Relation to Patient self/spouse/child/other**
Secondary Medical Insurance:	**Phone:**
Insurance ID No:	**Insurance Group No:**
Street Address:	**City/State/Zip:**
Subscriber Name (L,F,M): DOB:	**Relation to Patient self/spouse/child/other**

*****OTHER MEDICAL CONTACTS*****

Primary Care Physician:	**Phone:**
Street Address:	**City/State/Zip:**
Pharmacy:	**Phone:**
Street Address:	**City/State/Zip:**

MEDICAL HISTORY

Are you allergic to any medications? If yes, please list below along with a description of the reaction you experienced.

_____

_____

_____

_____

Are there any medications that you are currently taking including over the counter medicines and vitamins? If yes, please list.

_____

_____

_____

_____

Do you have a history of any of the following medical conditions? Please circle.

Atrial Fibrillation (A-Fib)	Y/N	Bleeding abnormally with Extractions, surgery, etc.	Y/N	Emphysema	Y/N
AIDS	Y/N	Blood Disease	Y/N	Endocarditis	Y/N
Alcohol/Drug Addiction	Y/N	Cancer Type_____	Y/N	Epilepsy/Seizures	Y/N
Anemia	Y/N	Chemotherapy	Y/N	Fibromyalgia	Y/N
Arteriosclerosis	Y/N	Chronic Fatigue	Y/N	Frequent Sore Throats	Y/N
Arthritis/Rheumatism	Y/N	Circulatory Problems	Y/N	Fainting or Dizziness	Y/N
Artificial Heart Valves	Y/N	Claustrophobic (Difficulty swallowing)	Y/N	Gastroesophageal Reflux (GERD)	Y/N
Artificial Joints	Y/N	Congenital Heart Lesions	Y/N	Glaucoma	Y/N
Asthma	Y/N	Congestive Heart Failure	Y/N	Hay Fever	Y/N
Autoimmune Disorder	Y/N	Cough, Persistent or Bloody	Y/N	Heart Attack	Y/N
Back or Shoulder Problems	Y/N	Diabetes	Y/N	Heart Disorder Type: _____	Y/N

MEDICAL HISTORY (Cont.)

Heart Murmur	Y/N	Memory Loss	Y/N	Surgery	Y/N
Heart Pacemaker	Y/N	Morning Dry Mouth	Y/N	Swollen Neck Glands	Y/N
Hepatitis Type_____	Y/N	Mitral Valve Prolapse	Y/N	Thyroid Problem	Y/N
Herpes	Y/N	Nervous Disorder	Y/N	Tonsillitis	Y/N
High Blood Pressure	Y/N	Osteoporosis	Y/N	Tuberculosis	Y/N
High Cholesterol	Y/N	Psychiatric Care	Y/N	Tumor or growth on Head or Neck	Y/N
HIV Positive	Y/N	Radiation Treatment	Y/N	Ulcer	Y/N
Injury to Head or Neck	Y/N	Respiratory Disease	Y/N	Venereal Disease	Y/N
Insomnia	Y/N	Rheumatic Fever	Y/N	Weight Loss, Unexplained	Y/N
Jaundice	Y/N	Shortness of Breath	Y/N	Women:	
Jaw Joint Surgery	Y/N	Sinus Problem	Y/N	Are you pregnant Due Date_____	Y/N
Kidney Disease	Y/N	Stomach, Intestinal Disease	Y/N	Are You Nursing	Y/N
Liver Disease	Y/N	Surgery	Y/N	Other _____	
Low Blood Pressure	Y/N				

Doctor's Notes:

_____

_____

_____

How often do you consume alcohol within 2-3 hours of bedtime?

Never Once a week Several days a week Daily Occasionally

How often do you take sedatives within 2-3 hours of bedtime?

Never Once a week Several days a week Daily Occasionally

How often do you consume caffeine (coffee, energy drinks, tea) within 2-3 hours of bedtime?

Never Once a week Several days a week Daily Occasionally

MEDICAL HISTORY (Cont.)

Do you or anyone in your family have a history of obstructive sleep apnea (OSA)?

_____

Do you or anyone in your family have a history of Cardiovascular disease (CVD)?

_____

Are you currently using a CPAP or oral device to treat OSA or snoring? Y/N

If so are you satisfied with its effectiveness?

_____

_____

Authorization

To the best of my knowledge all the questions have been answered correctly. I have received a copy of the HIPAA Privacy Notice and authorize release of information concerning my health care, advice and treatment provided for the purpose of evaluating and/or administering claims for my insurance. I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurances. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers and/or health practitioners. I give Dr. Stephen J. Gershberg permission to use my photo and models for laboratory communications, educational, and/or marketing purposes.

Person completing the form:

Signature _____ Date_____

Print Name _____ Date_____

If other than patient, indicate relationship: _____

If patient is a minor, I give consent for treatment necessary.

Signature_____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved

The Art of Dentistry & Main Line Snoring Solutions
By Dr. Stephen J. Gershberg
14 S Bryn Mawr Ave #200
Bryn Mawr, PA 19010

The Art of Dentistry

Stephen J. Gershberg, D.M.D.

New Patient Questionnaire

1. Are you dissatisfied with your teeth in any way? For example: color, shape, spaces, etc. _____
2. Do you or anyone you know snore or stop breathing at night? _____
3. Have you thought about bleaching your teeth?_____
4. Do you have any missing teeth? _____
5. Does food constantly get stuck between certain teeth? _____
6. Do you clench or grind your teeth? _____
7. Do you have any filling/bondings that bother you in any way? _____
8. Have you ever thought about invisalign or invisible braces? _____
9. Do you have any old mercury (silver) fillings that you would like replaced with a tooth colored fillings? _____
10. Are you currently in the middle of or plan to have any dental work done? _____
11. Who can we thank for your referral? _____
12. Any other concerns? _____

CPAP INTOLERANCE FORM

I have attempted to use the CPAP machine to manage my Obstructive Sleep Apnea but find it intolerable for the following reasons (please check all that apply):

- ☐ I find the device cumbersome and it interrupts my sleep
- ☐ The machine is noisy and negatively impacts my sleep or my bed partner's sleep
- ☐ I am unable to sleep on my back like the CPAP requires
- ☐ I am unable to tell a noticeable difference in my symptoms of sleep apnea when I wear the machine
- ☐ The pressure on my machine is too high
- ☐ I remove my CPAP unknowingly at night.
- ☐ I feel claustrophobic when I wear the mask.
- ☐ The CPAP mask cause me to have nose bleeds
- ☐ I have been unable to find-a mask that fits properly
- ☐ The mask leaks.
- ☐ The straps or headgear cause me discomfort
- ☐ Latex allergy
- ☐ I refuse to even attempt CPAP.

If other please explain(Please stay within the allowed space)

_____

_____

_____

I have found that I am unable to comply with the CPAP machine as a treatment for my Sleep Apnea. For this reason, I am seeking alternative treatment method for my condition. I realize that the treatments I am consenting to may help my sleep apnea, but may not completely alleviate it (particularly if my sleep apnea is severe). My physician has advised me of alternative therapies that may be used in conjunction with the treatments I am consenting to today.

Patient Name: _____

Date: _____

Patient Signature: _____

Sleep Disorder Assessment

Your physician is requesting that you complete this Sleep Assessment Form.
This form determines the need for you to have a sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your cardiovascular health and well being, but can be effectively treated.

Date _____ **Name:** _____

Phone Number _____ **Physician Name:** _____

Home Address _____

Part 1.

1. Have you ever been told you have Congestive Heart Failure? Yes ___ No ___
2. Have you ever been told you have Coronary Artery Disease? Yes ___ No ___
3. Have you ever had a stroke? Yes ___ No ___
4. Do you take 3 or more medications for high blood pressure? Yes ___ No ___
5. Have you ever experienced irregular heart rhythms (atrial fibrillation) Yes ___ No ___
6. Have you ever been told that you stop breathing at night? Yes ___ No ___
7. Do you have Diabetes? Yes___ No____

Part 2

1. Have you been told that you snore loudly? Yes ___ No ___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes ___ No ___
3. Does your family have a history of premature death in sleep? Yes ___ No ___
4. Is your neck size larger than 15.5 (female) or 17.0 (male) Yes ___ No ___
5. Have you ever been diagnosed with Obstructive Sleep Apnea? Yes ___ No ___
6. Are you currently being treated for sleep apnea? Yes ___ No ___

6a. If yes, are you using your apparatus every night? Yes ___ No____

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale: 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more 0 1 2 3
2. Sitting and talking to someone..... 0 1 2 3
3. Sitting and reading..... 0 1 2 3
4. Watching TV..... 0 1 2 3
5. Sitting inactive in a public place..... 0 1 2 3
6. Lying down to rest in the afternoon..... 0 1 2 3
7. Sitting quietly after lunch without alcohol..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic... 0 1 2 3

Total score _____

Physician Signature: _____ **Date:** _____

Chief Complaint

Name: _____ DOB: _____

Date: _____

Please answer the following questions below

What is your main chief complaint for which you are seeking treatment today? (Please Explain)

_____

_____

Number the following complaints from 1 to 5 with #1 being the most important to you. Please use each number only once.

_____ Frequent heavy snoring that affects sleeping with others

_____ Daytime sleepiness

_____ I have been told that I stop breathing at night

_____ I have trouble falling asleep

_____ I occasionally wake up gasping

_____ Nighttime choking spells

_____ I feel unrefreshed in the morning

_____ My throat is sore or dry in the morning

_____ I frequently have morning headaches

_____ I have swelling in my ankles and/or feet

_____ I grind my teeth

_____ My jaw clicks when opening or closing

_____ My snoring or apnea interferes with intimacy

_____ I find the CPAP difficult to travel with

_____ I dislike the lines on my face that the CPAP leaves

_____ It is required by my job to have my apnea treated

_____ Other

_____

_____

The Art of Dentistry

Stephen J. Gershberg, D.M.D.

Office Financial Policy

We are committed to providing you with the best possible care, while making your dental treatment affordable to all of our patients. In order to achieve these goals and to keep the rising costs of dentistry to a minimum, we ask for your assistance and understanding of our policy.

1. **Payment for services is due at the time services are rendered, by you, the patient or guardian, unless prior payment arrangements have been made and approved by our financial coordinator in advance of the appointment.** We offer the following:

    - **Cash or Check**
    - **Visa, MasterCard, or Discover**
    - **Debit bank cards**
    - **Care Credit Financing (www.carecredit.com)**

2. **If you have dental insurance, we will be happy to process your insurance claim, for your maximum reimbursement, once your balance has been paid in full.** While the filing of claim forms is a courtesy that we extend to our patients, **all charges are your responsibility at the time of treatment.**

3. **Returned checks and balances over 30 days are subject to any resulting bank fees that we incur and interest charges of 1.5% per month.**

4. **In the event of a broken appointment without 24 hours notice, there may be a charge of $50.00 per scheduled appointment with our hygienist and $100.00 per scheduled appointment with Dr Gershberg, except if the Large Case Refund Policy has already been signed by you, the patient or guardian.**

If you have any questions regarding this policy or your insurance, please do not hesitate to ask.

Patient/Guardian Signature:_____ date:_____

Witness Signature:_____ date:_____

Notice of Privacy Practices
Stephen J. Gershberg, D.M.D., P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

"You May Refuse To Sign This Acknowledgement"

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (please circle one)

1. **Individual refused to sign**
2. **Communications barrier prohibited obtaining the acknowledgement**
3. **An emergency situation prevented us from obtaining the acknowledgement**
4. **Other (Please Specify)** _____