TODAY'S SMILE CENTER
Sam G. Shamoon, DDS, MAGD

Dear Valued Patient,

We would like to take this time and opportunity to welcome you to our office. Our patients' dental health is our first concern. Our goal is that our patients experience a relaxed atmosphere. We schedule enough time with every patient so that personalized treatment plans and procedures can be discussed. Our patients feel empowered with knowledge and the freedom to ask questions in an unpressured conversation during their appointments so they can make informed decisions regarding their dental health.

Our philosophy is based on prevention of dental disease. Our duty is not complete unless we have given you all the tools to protect your investment.

Enclosed you will find patient information and medical history forms. Please complete these forms and bring with you to your appointment. In addition, please bring the following:

Insurance card(s)
Driver's license / State ID
A list of all your medication and the dosage/directions
Copies of any previous X-rays, records…etc)

Please arrive 10-15 minutes before your scheduled appointment time to allow us to process all of your paper work. If you are running late for your appointment (20 minutes or more), you will be asked to reschedule your appointment.

Thank you for your cooperation. If you have any questions, feel free to contact our office. We look forward to seeing you soon.

Healthfully yours,

Sam G. Shamoon, DDS, PC and Staff
Master Academy of General Dentistry

SGS/nk
Enclosures

600 West Eleven Mile Road, Berkley, Michigan 48072. (248) 543-1778

WELCOME

The Benefits Of A Happy, Healthy Smile Are Immeasurable! Our Goal Is To Help You Reach Maximum Oral Health.
Please Fill Out This Form Completely. The Better We Communicate, The Better We Care For You.

PATIENT'S NAME _____ [ ] [ ]
Last First Initial Date of Birth Male Female

IF CHILD, PARENT'S NAME _____
Last First Initial E-Mail Address

Single[ ] Married[ ] Minor[ ] How Do You Prefer To Be Addressed: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Dr. [ ] First Name [ ] Nick Name _____

ADDRESS _____
Street City State Zip Code

PHONE: Weekday: 9 AM – 5 PM. _____ 5 PM – 9 PM. _____ Weekends _____ Bus: _____

BUSINESS ADDRESS _____ PATIENT/PARENT SOCIAL SECURITY #: _____

PATIENT/PARENT EMPLOYED BY _____ POSITION _____ HOW LONG _____

SPOUSE/PARENT NAME _____
Last First Initial Date of Birth

PERSON RESPONSIBLE FOR DENTAL INVESTMENT _____ DRIVERS LICENSE # _____

WHO MAY WE THANK FOR THIS REFERRAL _____ OTHER FAMILY MEMBERS IN THIS PRACTICE _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize the use of my email address for office-patient communications and notifications.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services; I understand I am financially responsible for payments in full of all accounts. In case of default of payment, I promise to pay any legal interest on balance due, together with any collection costs (30%) and reasonable attorney fees incurred to affect collection on this account. Unpaid balances may be subject to additional collection fees of 30% if this account is referred to a third party debt collector or attorney.

MEDICAL HISTORY

Are You Under A Physician's Care? ☐YES ☐NO Since When? _____ Why? _____
Physician's Name _____ Telephone _____ **Taking Biophosphonates (Fosamax, Actonel, Boniva…etc)?** ☐YES ☐NO
Taking Medications? ☐YES ☐NO If Yes, Please List Medications: _____
(Women) Are You Pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO Taking Birth Control Pills? ☐YES ☐NO
Check (✓) If You Have Or Have Had Any Of The Following:

☐A.I.D.S.	☐Anemia	☐Arthritis, Rheumatism	☐Artificial Heart Valve	☐Artificial Joints/Prosthesis
☐Asthma or Emphysema	☐Back Problems	☐Blood Disease/Hemophilia	☐Cancer (Active)	☐Chemical Dependency
☐Alcohol > 3 Drinks Per Day	☐Bone Disease (Paget's)	☐Circulatory Problems	☐Congenital Birth Defects	☐Cortisone Treatment
☐Cough, Persistent	☐Cough Up Blood	☐Diabetes	☐Epilepsy	☐Fainting
☐Fibrous Dysplasia	☐Glaucoma	☐Headaches	☐Heart Murmur	☐Heart Problems
☐Hepatitis	☐High/Low Blood Pressure	☐H.I.V. Positive	☐Immune Deficiency	☐Kidney Disease
☐Liver Disease	☐Lupus	☐Multiple Myeloma	☐Mitral Valve Prolapse	☐Nervous Problems
☐Pacemaker	☐Psychiatric Care	☐Radiation or Chemotherapy	☐Rheumatic or Scarlet Fever	☐Respiratory Disease
☐Shortness of Breath	☐Skin Rash or Scleroderma	☐ Stroke	☐ Swelling Of feet/Ankles	☐ Thyroid Problems
☐Tobacco Habit	☐Tuberculosis (T.B.)	☐ Tumors	☐Ulcer, Stomach	☐Venereal Disease

ALLERGIES

☐Aspirin	☐Barbiturates	☐Codeine	☐Local Anesthetic
☐Penicillin	☐Sulfa	☐Latex	☐Other _____

DENTAL HISTORY

Purpose of initial visit _____ Date of Last Dental Care? _____
Date of Last Prophy? _____ Date Of Last Dental X-rays? _____ (Child) Is This The First Visit To The Dentist? ☐YES ☐NO
Has There Been any Injuries To The Teeth Or Face? ☐YES ☐NO Were Any Teeth (Baby Or Adult) Been Removed By Extraction? ☐YES ☐NO
Are You A Mouth Breather? ☐YES ☐NO How Often Do You Brush Your Teeth? _____ How Often Do You Use Dental Floss? _____
Check (✓) if you have or Have Had Problems with any of the Following:

☐Bad Breath	☐Bleeding Gums	☐Broken Or Missing Fillings	☐Cold Sores	☐Excessive Bleeding
☐Frequent Headaches	☐Grinding Teeth	☐Neck And Shoulder Pain	☐Periodontal Treatment	☐Sensitivity To Hot Or Cold

SMILE EVALUATION

How Do You Feel About Your Teeth In General? _____

Does The Appearance Of Your Teeth Please You?	☐Yes	☐No	Do You Like The Shape Of Your Teeth?	☐Yes	☐No
Do You Like The Way Your Teeth Come Together?	☐Yes	☐No	Do You Like The Color Of Your Teeth?	☐Yes	☐No

PRIVACY NOTICE

I HAVE BEEN OFFERED THIS OFFICE'S PRIVACY NOTICE & FOR THE OPPORTUNITY TO ASK QUESTIONS AND/OR OBTAIN A PAPER COPY

SIGNATURE

I CERTIFY THAT I HAVE RECEIVED THIS OFFICE'S PATIENT POLICY AND CERTIFY THE ABOVE INFORMATION IS COMPLETE & ACCURATE:

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

600 West Eleven Mile Road, Berkley, Michigan 48072. (248) 543-1778

SOFT TISSUE EXAM

Date													
1. Lymphatics													
2. TMJ													
3. Lips													
4. Buccal Mucosa													
5. Floor Of Mouth													
6. Tongue													
7. Hard Palate													
8. Soft Palate													
9. Pharynx													
Initials													

[ ] INITIAL TMJ Analysis

R I L

I 10mm
I 20mm
I 30mm
I 40mm
I 50mm
I 60mm

- ❑ Pain R L _____
- ❑ Crepitus R L _____
- ❑ Popping R L _____

NOTES

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

[ ] INITIAL OCCLUSION

Molar Class	Right I - II - III - Div. 1 - 2	Left I - II - III - Div. 1 - 2
Canine Class	Right I - II - III - Div. 1 - 2	Left I - II - III - Div. 1 - 2
Over-jet	____ mm	Over-bite ____ mm
U/Mid-line	____ mm R – L	L/Mid-line ____ mm R – L
Cross-bite	Anterior	Posterior
Habits:	Thumb Tongue	Other _____

Patient: _____

Initial Exam ____/____/____

Maximum Pocket Depth Upon Probing

UR
Posterior ≤ _____ mm Tooth # _____.
Anterior ≤ _____ mm Tooth # _____.

UL
Posterior ≤ _____ mm Tooth # _____.
Anterior ≤ _____ mm Tooth # _____.

LR
Posterior ≤ _____ mm Tooth # _____.
Anterior ≤ _____ mm Tooth # _____.

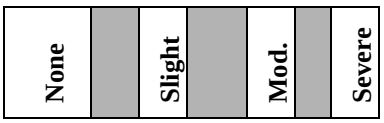
LL
Posterior ≤ _____ mm Tooth # _____.
Anterior ≤ _____ mm Tooth # _____.

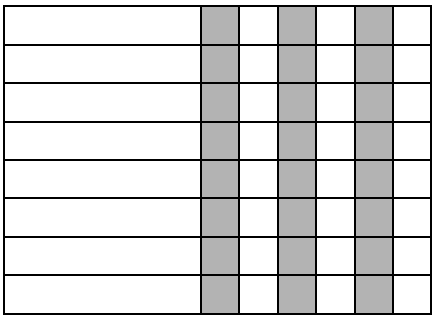
Mobilities ≥ 2: _____

Furcation Involvement: _____

Dx: _____

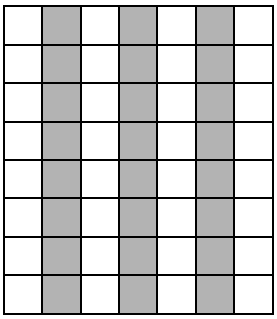
Bleeding Upon Probing





Supra-gingival Calculus

Bone Loss



Radiographic Calculus

Stain

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Smile Analysis:

Your smile affects your self-image and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile. Go to a mirror, smile as wide as you can, and ask yourself the following questions:

How Do You Feel About Your Teeth In General? _____

	Yes	No
Are any of your teeth yellow, stained or somewhat discolored?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Do you have any gaps or spaces between your teeth?	☐	☐
Are any of your teeth turned, crooked, or uneven?	☐	☐
Are you missing any teeth?	☐	☐
Do you see any pitting or defects on the surfaces of your teeth?	☐	☐
Are the edges of any teeth worn down, chipped or uneven?	☐	☐
Do any of your teeth appear too small, short, large or long?	☐	☐
Do you have any prior dental work that appears unnatural?	☐	☐
Do you have any crowns or bridges that appear dark at the edge of your gums?	☐	☐
Do you have any gray, black or silver (mercury) fillings in your teeth?	☐	☐
Do you have a "gummy" smile (too much of your gums show when smiling)?	☐	☐
Are your gums red, sore, puffy, bleeding or receded?	☐	☐
Does the appearance of your smile inhibit you from laughing or smiling?	☐	☐
When being photographed, do you smile with your lips closed instead of flashing a full smile?	☐	☐
Are you self-conscious about your teeth or smile?	☐	☐
Would you like to change anything about the appearance of your teeth or smile?	☐	☐
Frequent Headaches?	☐	☐
Grinding Teeth?	☐	☐
Neck And Shoulder Pain?	☐	☐
Sensitivity To Hot Or Cold?	☐	☐
Do You Like The Way Your Teeth Come Together?	☐	☐

What is the main reason that you are here today? _____
In what order do want to proceed with your treatment? _____

If you had a Magic Wand and can get all of the dental treatment you want, how can you imagine your teeth would feel and look like?

Patient Signature: Date:

600 West Eleven Mile Road • Berkley •Michigan 48072 • (248) 543-1778

SLEEP GROUP SOLUTIONS

TODAY'S SMILE CENTER
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Initial Patient Sleep Screening Form v. 1.0

Patient Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations: (0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading……	0	1	2	3
Watching television……	0	1	2	3
Sitting in a public place……..	0	1	2	3
As a passenger in a car for one hour……..	0	1	2	3
Driving a car stopped for a few minutes in traffic……..……..	0	1	2	3
Sitting & talking to someone…….	0	1	2	3
Sitting down quietly after lunch without alcohol……..……	0	1	2	3
Lying down to rest in the afternoon…….…….	0	1	2	3

Total Score: _____

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question		No(0)	Yes(1)
BMI (See Attached Chart):	_____ Is it greater than or equal to 30?	0	1
Neck Circumference	_____ Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15lbs in the past 6 months?		0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question	No(0)	Yes(1)
Do you snore?.....	0	1
You, or your spouse, would consider your snoring louder than a person talking…	0	1
Your snoring occurs almost every night……...	0	1
Your snoring is bothersome to your bed partner……....	0	1
Do you feel that in some way your sleep is not refreshing or restful?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day and have difficulty staying awake?.....	0	1
Do you have trouble remembering things or paying attention during the day?.....	0	1
Do you have high blood pressure?.....	0	1

Total Score: _____

Section 4: Prior Diagnosis

Have you previously been diagnosed with sleep apnea?	No(0)	Yes(1)
If Yes:	0	1
When were you diagnosed? (Approx mo/yr) _____		
Were you put on CPAP Therapy for treatment? _____		
Are you still using your CPAP every night? _____		

Total Score: _____

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate. Use back of page if necessary.)

Patient Signature:_____ **Date:** ____/____/_____

OFFICE USE ONLY
Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.
_____ ESS Score ≥ 8? _____ Pt. Eval ≥ 2?_____ Subjective Sleep Eval ≥ 3?_____ Prior OSA Diagnosis ≥ 1?

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Office Billing Policy

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Insurance co-pays will be collected on the date of service. If you are not able to pay your co-payment today, please reschedule your appointment. For your convenience, our office accepts checks, Visa, MasterCard, Discover, American Express and cash.

Private pay (no-insurance) must pay on the date of service.

Our returned check fee is $30.00.

If after 90 days, we have not received payment from your insurance company; our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles and/or co-pays of your insurance coverage**. Failure to notify us will result in non-covered expenses which will be your responsibility.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply.

Cancellations/Broken Appointments

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment.

We require a two-business day advanced notice for any changes or cancellations of your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however, understand that illness and emergencies occur and we do accommodate for those rare instances.

A fee will be charged to your account for not honoring this policy in the amount of $80.00/hour. Thank you so much for putting your faith and trust in Today's Smile Center, P.C.

_____
Print Patient Name

_____ _____
Signature of Patient and/or Guardian if Under 18 Years Old Date

_____
Relationship to Patient