Mindy Munowitz, DDS
creating healthy smiles!
SmilesOhio.com

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date _____

Name _____
Last First MI

Nickname _____ Birthdate _____

Address _____

_____

E-mail Address _____

Home Phone No. _____ Cell Phone _____

How do you wish to be contacted? (please check) ___ Home ___ Work ___ Cell ___ Email

Social Security Number _____ Driver's License Number _____

Married _____ Single _____ Divorced _____ Widowed _____

Children's Names _____

Referred to us by _____

Your Former Address _____

IN CASE OF AN EMERGENCY

Closest relative not living with you _____

Address _____ Phone Number _____

Neighbor _____ Phone Number _____

INSURANCE INFORMATION

Dental

Name of Insured _____
Last First MI

Insured's Social Security Number _____

Insured's Birth Date _____ ID# _____ Group# _____

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

_____
Street City State Zip Code

9393 Cincinnati - Columbus Road
West Chester, Chio 45069
513.755.8000
Info@smilesohio.com

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Primary Care Physician Name _____

   Address _____

   General Dentists Name _____

   Address _____ Phone # _____

6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____

8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list: _____

9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Emphysema	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Cough	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Tuberculosis (TB)	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Yellow Jaundice	YES	NO
Heart Murmur	YES	NO	Hay Fever	YES	NO	Blood Transfusion	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Drug Addiction	YES	NO
Mitro Valve Prolapse	YES	NO	Allergies or Hives	YES	NO	Hemophilia	YES	NO
Scarlet Fever	YES	NO	Diabetes	YES	NO	Venereal Disease		
Artificial Heart Valve	YES	NO	Thyroid Disease	YES	NO	(Syphilis, Gonorrhea)	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Cold Sores	YES	NO
Heart Surgery	YES	NO	Chemotherapy (Cancer, Leukemia)	YES	NO	Fever Blisters	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Arthritis	YES	NO	Epilepsy or Seizures	YES	NO
Anemia	YES	NO	Rheumatism	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Cortisone Medicine	YES	NO	Nervousness	YES	NO
Kidney Trouble	YES	NO	Glaucoma	YES	NO	Psychiatric Treatment	YES	NO
Ulcers	YES	NO	Pain in Jaw Joints	YES	NO	Sickle Cell Disease	YES	NO
Cosmetic Surgery	YES	NO	A.I.D.S.	YES	NO	Bruise Easily	YES	NO

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition, or problem not listed? ..... YES NO
18. Have you ever been diagnosed with Sleep Apnea? ..... YES NO
19. Has your medical doctor ever said you need to be pre-medicated for dental visits? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____ Are you taking birth control pills? ☐ YES ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____/_____/_____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____
And further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to page legal interest on the indebted ness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient _____

PATIENT HIPAA AWARENESS

With my permission, Mindy Munowitz, D.D.S. L.L.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mindy Munowitz, D.D.S. L.L.C.'s Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to the Privacy Officer.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mindy Munowitz, D.D.S. L.L.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Mindy Munowitz, D.D.S. L.L.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my permission, the office of Mindy Munowitz DDS L.L.C. may email to my home or other designated location any times that assist the practice in carrying out TPO, such as appointment reminder and patient statements. I have the right to request that Mindy Munowitz DDS L.L.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this, I am allowing Mindy Munowitz DDS L.L.C. to use and disclosure my PHI and TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date

SMILES OHIO FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to treatment.

General:
Understand that regardless of any insurance status, you are responsible for any and all professional services rendered. This includes but not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist

MISSED APPOINTMENTS:
There will be a fee for appointments broken without 24 hours' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. Please help us serve you better by keeping your scheduled appointments.

INSURANCE:
As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** Your insurance is a contract between you and your insurance company/employer: therefore, all charges are your responsibility. We are not a party to that contract. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. All insurance benefits are payable to you the patient and I agree to release any information necessary for the insurance company to process claims. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
For those without insurance please ask about our Smiles Ohio Wellness Plan for existing patients.

Payment:
We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options: Cash, Money Orders, Check, Visa, MasterCard, Discover and American Express.
Checks returned to the office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.
Unpaid balance over 90 days old will be subject to a monthly interest of 1.5(APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney fees, and court costs associated with recovery of the monies due on the account.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice

Patient's Name:_____

Signature of Patient or Parent/Guardian If Minor:

_____Date:_____

CONSENT TO DENTAL TREATMENT

I, _____,_____

Residing at (address)_____

_____

REQUEST AND AUTHORIZE:

Mindy Munowitz, DDS, her Dental Hygienists and Dental Assistants to provide treatment for:

Patient Name_____

Utilizing, but not limited to the following procedures:

- Clinical Examinations
- Radiographic (x-ray) examinations
- The use of ozonated water, ozonated olive oil, ozonides and oxygen/ozone gas mixtures to disinfect the mouth, soft tissues, (gums, cheeks, tongue and associated structures) tooth structure, root canals, dental implants, extraction sites, and any infections in the oral cavity or associated structures as defined by the American Dental Association (ADA) definition of Dentistry.

  Dentistry: "Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law."
  (As adopted by the 1997 ADA House of Delegates)

- Dental Cleaning Procedures, including: a) Scaling the teeth (removal of hard deposits) with hand instruments or ultrasonics. b) Root Planing of the teeth. (removal of hard deposits from root surfaces) c) Polishing the teeth.
- Removal of tooth structure and previous restorations as required for restoring cracked, fractured or decayed tooth structure.
- Removal of tooth structure and restorations or addition of composite to tooth structure to achieve occlusal balance. (bite adjustments)
- Obtaining impressions (direct or optical) of the oral tissues for removable appliances such as: orthodontic retainers, night guards, TMJ appliances, dentures, removable partial dentures or for any other type of appliance required for my treatment. Obtaining impressions (direct or optical) of the oral tissues for permanent restorations such as: laboratory processed or in office processed crowns, bridges, veneers, etc.

I understand that unforeseen conditions may arise during treatment and may require a change in the procedure being performed. I consent to the performance of any additional procedures that may be necessary to complete the procedure. (For example: during the removal of decay from the tooth for a filling, the nerve may be exposed necessitating a root canal or extraction **OR**, a piece of tooth, filling material or appliance can be aspirated requiring a surgical procedure)

I consent to the proposed treatment plan (see attached treatment plan) and any verbal changes to the plan, after confirming that I have been advised of the risks, advantages and disadvantages of the treatments and the consequences of not performing the procedures. (Example: not extracting or performing a root canal on an infected, abscessed tooth can cause serious health issues)

I consent to the prescribing of prescription pharmaceutical medications and the recommendation of non-prescription vitamins, minerals, biological, homeopathics and other associated neutraceuticals for my treatment.

I consent to the injection and administration of local anesthetics, analgesics, vitamins (IV, IM and Subcutaneous), oxygen/ozone gas, homeopathics, or any other agent that may be necessary for the treatment of my condition(s). I understand that there is an element of risk inherent in the injection and administration of any injectable agent. These risks include, but are not limited to: Herxheimer reactions, (healing crisis) adverse drug reactions, allergic reactions, cardiac arrest, tachycardia, swelling, bruising, pain, transient or permanent nerve damage, asthmatic reactions, needle tract infection and other unspecified injuries.

I consent to the treatment that I am seeking from Mindy Munowitz,DDS, and I am aware that there are risks in any dental procedure that is performed. I recognize that the practice of dentistry is not an exact science and I understand that there has been no warranty or guarantee that the treatment and results I am seeking will be successful.

I have been offered an explanation of my proposed treatment and all the statements in this consent form. I had the opportunity to ask questions concerning my proposed treatment and the information in this consent form.

Patient or Guardian Signature _____Date_____

Dentist Signature _____Date_____

Witness Signature _____Date_____

November 2012

TMJBDS® SLEEP - QUESTIONNAIRE

Please answer the following questions on your average sleep habits/quality during the past month.

Going to sleep		YES	NO	Unsure
Do you have any problems going to bed or falling asleep?		☐	☐	☐
Do you have a regular bedtime?		☐	☐	☐
Do you have a regular wake time?		☐	☐	☐
Does your bedtime/wake time differ greatly between weekdays and weekends?		☐	☐	☐
While sleeping		YES	NO	Unsure
Do you often wake up at night after falling asleep?		☐	☐	☐
Do you snore while sleeping?		☐	☐	☐
Please answer these → additional questions if you answered "Yes" to the question above.	Do you snore on most nights (more than 3 nights per week)?	☐	☐	☐
	Do you snore for more than half the night's sleep duration?	☐	☐	☐
	Do you snore loudly?	☐	☐	☐
Do you have heavy/loud loud breathing habits while sleeping?		☐	☐	☐
Do you have your mouth open while sleeping?		☐	☐	☐
Do you have difficulty breathing at night while sleeping?		☐	☐	☐
Has it been reported that you stop breathing or gasp during sleeping?		☐	☐	☐
Do you have regular nightmares, sleep walking or other unusual sleep behaviours?		☐	☐	☐
Do you think you are getting enough sleep?		☐	☐	☐
Have you ever had a sleep study (PSG or Portable take home study)		☐	☐	☐
While awake		YES	NO	Unsure
Do you feel overtired or sleepy during the day?		☐	☐	☐
Do you wake up feeling unrefreshed in the morning?		☐	☐	☐
Do you find it difficult to wake up in the morning?		☐	☐	☐
Do you wake up with headaches in the morning?		☐	☐	☐
Do you take excessive naps during the day?		☐	☐	☐
Do you tend to breathe through the mouth while awake?		☐	☐	☐
Do you have a dry mouth when you wake up in the morning?		☐	☐	☐
Do you occasionally fall asleep during the day...	... when you are busy or active?	☐	☐	☐
	... when you are driving or stopped at a traffic light?	☐	☐	☐
	... when you are sitting and talking to someone?	☐	☐	☐
	... when you are sitting or inactive in a public place?	☐	☐	☐
Have you been previously or currently treated for high blood pressure?		☐	☐	☐
Are you overweight?		☐	☐	☐

Date:	Name:	Age:	D.O.B (DD/MM/YYYY):
Address:		Postcode:	Mobile Number:
Occupation:		Health Fund:	
Referred by:		Payment Method:	