

# Welcome!



## Patient Information

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First Middle Initial

Street Address: \_\_\_\_\_  
Street City State Zip

If student, permanent address: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Driver's License No. \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Other: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Would you like us to send you an email or text message to remind you of your appointments?

Yes  No  If not we will call you the day before to confirm your appointment.

Please consider other patients and give at least 24 hours notice to change your appointment.

Spouse/Guardian Name: \_\_\_\_\_ *DOB* *SS#*

Spouse's Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Whom may we thank for sending you to our office? \_\_\_\_\_

## Insurance Information

Please note we are not a participating provider for any insurance network.

Primary Dental Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_/\_\_\_/\_\_\_

Subscriber's SS# or ID#: \_\_\_/\_\_\_/\_\_\_ Group#: \_\_\_\_\_

Secondary Dental Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_/\_\_\_/\_\_\_

Subscriber's SS# or ID#: \_\_\_/\_\_\_/\_\_\_ Group#: \_\_\_\_\_



J. Craig Scasta, DDS  
Robert A. Hall, DDS

## Symptom Check List

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please check any of the following symptoms which may apply to you.

### Headaches

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Migraines                             | <input type="checkbox"/> Tension Headaches |                                     |
| <input type="checkbox"/> Other _____                           |  |                                     |
| <input type="checkbox"/> How Often? _____                      |  |                                     |
| <input type="checkbox"/> Top of Head                           | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Forehead                              | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Back of Head<br>(occipital)           | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Temples                               | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Behind Eyes                           | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in Neck                          | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in Ear                           | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Dizziness<br>(vertigo)                | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in jaw Joint                     | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Clicking or Popping<br>Sound in Joint | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in shoulder                      | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Ear congestion                        | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Tinnitus<br>(ringing sound in ears)   | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Facial Pain<br>(nonspecific)          | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Grating sound in<br>Joint             | <input type="checkbox"/> Left Side         | <input type="checkbox"/> Right Side |

- |                                   |                              |                             |
|-----------------------------------|------------------------------|-----------------------------|
| Partial inability to open mouth   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Face Muscle twitch                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty swallowing             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty breathing through nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty chewing                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### Occlusal Habits

- |   |                             |                             |
|---|-----------------------------|-----------------------------|
| <input type="checkbox"/> Clenching                | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <input type="checkbox"/> Grinding on teeth        | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <input type="checkbox"/> Teeth hit in front first |                             |                             |
| <input type="checkbox"/> Gum chewing              |                             |                             |
| <input type="checkbox"/> Pencil biting            |                             |                             |
| <input type="checkbox"/> Cheek biting             |                             |                             |
| <input type="checkbox"/> Pipe smoking             |                             |                             |
| <input type="checkbox"/> Nail biting              |                             |                             |
| <input type="checkbox"/> Other _____              |                             |                             |

### Postural Habits

- |   |
|---|
| <input type="checkbox"/> Phone cradling     |
| <input type="checkbox"/> TV watching        |
| <input type="checkbox"/> Shoulder bag       |
| <input type="checkbox"/> Leans chin on hand |
| <input type="checkbox"/> Heavy lifting      |
| <input type="checkbox"/> Pipe smoking       |
| <input type="checkbox"/> Nail biting        |
| <input type="checkbox"/> Other _____        |

### Additional Comments

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## List any medications which have caused an allergic reaction:

- Antibiotics  
  Aspirin  
  Barbiturates  
  Codeine  
  Iodine  
  Latex  
  Local anesthetics

- Metals  
  Penicillin  
  Plastic  
  Sedatives  
  Sleeping pills  
  Sulfa drugs

Other allergens:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## List any medications you are currently taking:

- Antacids  
  Antibiotics  
  Anticoagulants  
  Antidepressants  
  Anti-inflammatory drugs  
     (non-steroid)  
  Barbiturates  
  Blood thinners

- Codeine  
  Cortisone  
  Diet pills  
  Heart medication  
  High blood pressure medication  
  Insulin  
  Muscle relaxants  
  Nerve pills

- Pain medication  
  Sleeping pills  
  Sulfa drugs  
  Tranquilizers

Other current medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical History

- Anemia  
  Arteriosclerosis  
  Asthma  
  Autoimmune disorders  
  Bleeding easily  
  Chronic sinus problems  
  Chronic fatigue  
  Congestive heart failure  
  Current pregnancy  
  Diabetes  
  Difficulty concentrating  
  Dizziness  
  Emphysema  
  Epilepsy  
  Fibromyalgia  
  Frequent sore throats  
  Frequently awakens with  
     a dry mouth  
  Gastroesophageal Reflux  
     Disease (GERD)  
  Hay fever  
  Heart disorder  
  Heart murmur

- Heart pounding or beating  
     irregularly during the night  
  Heart pacemaker  
  Heart valve replacement  
  Heartburn or a sour taste  
     in the mouth at night  
  Hepatitis  
  High blood pressure  
  Immune system disorder  
  Injury to  
      Face    Neck  
      Head    Mouth    Teeth  
  Insomnia  
  Irregular heart beat  
  Jaw joint surgery  
  Low blood pressure  
  Memory loss  
  Migraines  
  Morning dry mouth  
  Muscle spasms or  
     cramps  
  Needing extra pillows to  
     help breathing at night

- Nighttime sweating  
  Osteoarthritis  
  Osteoporosis  
  Poor circulation  
  Prior orthodontic treatment  
  Recent excessive weight  
     gain  
  Rheumatic fever  
  Shortness of breath  
  Swollen, stiff or painful  
     joints  
  Thyroid problems  
  Tonsillectomy (have had)  
  Wisdom teeth extraction

Other medical history:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## ASSESSMENT OF DAYTIME SLEEPINESS EPWORTH SLEEPINESS SCALE

Please complete the questions below. This is a measure of dozing or falling asleep, not just feeling tired. This is to reflect how you have felt most recently.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze	2 = moderate chance of dozing
1 = slight chance of dozing	3 = high chance of dozing

It is important that you put a number (0-3) in each of the 8 boxes.

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place, for example, a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you've had no alcohol)	
In a car, while stopped in traffic	

Height : \_\_\_\_\_

Weight: \_\_\_\_\_

BMI: \_\_\_\_\_

Neck Circumference (measured by staff)

\_\_\_\_\_ cm

### Stop Bang Questionnaire

**Snoring:** Do you snore loudly (Louder than talking or loud enough to be heard through closed doors)

Yes                      No

**Tired:** Do you often feel tired, fatigued, or sleepy during the day?

Yes                      No

**Observed:** Has anyone observed that you stop breathing during your sleep?

Yes                      No

**Blood Pressure:** Do you have or are you being treated for high blood pressure?

Yes                      No

**BMI more than 35 kg/?**

Yes                      No

**Age over 50 years?**

Yes                      No

**Neck circumference greater than 40 cm?**

Yes                      No

**Gender, Male?**

Yes                      No

**PATIENT RECORDS REQUEST FORM**

**J. Craig Scasta, DDS, PA**  
**Robert A Hall, DDS, Inc.**  
1615 Barak Lane  
Bryan, TX 77802  
Ph: 979-260-2626 / Fax: 979-260.2631

This form entitles our office to request any necessary records from previous dentist, and or physicians if needed.

Name of Patient Whose Record is Requested \_\_\_\_\_

DOB \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Please provide a copy of the record as indicated below:**

- The full health record maintained by this provider/practice
- The health record for the following time frame: \_\_\_\_\_ through \_\_\_\_\_
- A specific section of the health record as described below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- A summary of the information requested above is adequate to fulfill this request.
- As permitted by federal and state law, I understand that a fee of \_\_\_\_\_ cents per page will be charged for copying the records along with a clerical fee of \_\_\_\_\_. In addition, a fee of \_\_\_\_\_ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient \_\_\_\_\_

Signature of Authorized Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

**ACKNOWLEDGEMENT  
OF  
PRIVACY PRACTICES**

J. Craig Scasta, DDS, PA  
Robert A Hall, DDS, Inc.  
1615 Barak Lane, Suite #2  
Bryan, TX 77802  
979-260-2626

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy 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 operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_  
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**For Office Use Only:**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

**Submit form**

J. Craig Scasta, D.D.S. and Robert A. Hall, D.D.S.  
1615 Barak Lane Suite 2, Bryan, Tx. 77802  
Phone: (979) 260-2626

### FINANCIAL POLICY

Thank you for choosing our practice as your dental care provider! We look forward in beginning our dental friendship together and are committed to your treatment being successful! Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **FINANCIAL POLICY**, which we require you to read and sign before treatment.

#### DENTAL INSURANCE / MEDICAL INSURANCE

Insurance is a contract between you and your insurance company. We are **NOT CONTRACTED** with **ANY** insurance company and are considered **OUT OF NETWORK**. We will assist you in filing and will accept assignment of **DENTAL BENEFITS**. However, if your insurance has not paid within sixty (60) days from the date of service you will be sent a statement and payment is expected by the due date.

#### WE ARE NOT A MEDICAID OR MEDICARE PROVIDER.

#### USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

#### PAYMENT

Payment is due at the time of service. In the event you are sent a statement then payment is due by the due date. We accept **CHECK, CASH, VISA/ MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.**

If you have any questions regarding this financial policy please feel free to ask one of our team members. Welcome to our practice and we look forward in beginning our dental friendship!

Patient / Guardian signature: \_\_\_\_\_