Beachwood SMILES
Family & Cosmetic Dentistry
Yoav Y. Taub, DDS

24300 Chagrin Blvd., Ste 306
Beachwood, OH 44122
(216) 292-9920 (216) 292-6883
SmilesourceonChagrin.com

Name:_____ Preferred Name:_____ ☐Male ☐Female

Address: _____ City:_____ State: _____ Zip: _____

SSN:_____ DOB: _____ Email Address: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Employer/Occupation: _____ Marital Status: _____

How did you hear about us? _____Contact via email or by phone?_____

Primary Insurance

Subscriber Name: _____ Relationship to patient:_____ Subscriber DOB:_____

Subscriber SSN: _____ Subscriber Employer: _____

Insurance Company: _____ Insurance Address: _____

Insurance Phone: _____ Policy #: _____Group #: _____

Secondary Insurance

Subscriber Name: _____ Relationship to patient:_____ Subscriber DOB:_____

Subscriber SSN: _____ Subscriber Employer: _____

Insurance Company: _____ Insurance Address: _____

Insurance Phone: _____ Policy #: _____Group #: _____

Assignment and Release

I, the undersigned, certify that I (or my dependents) will personally cover all charges rendered or have insurance coverage and assign directly to Beachwood Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Part Signature: _____ Date: _____

Relationship to patient: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Parent/Guardian Signature: _____

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Dental History

Have you ever had unfavorable dental experiences? ☐ Yes ☐ No

Why did you leave your previous dental provider?

_____

_____

How can we better accommodate you during your dental visit?

_____

Medical History

Primary Physicians Name: _____ Phone: _____

Date of last visit: _____ Allergies? _____

Are you currently under the care of a physician? If so, why?

_____

Please list any surgical procedures you have had done: _____

Please list any medications you are currently taking: _____

Are you pregnant/breastfeeding? ☐Yes ☐ No

Are you on birth control? ☐Yes ☐ No

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Glaucoma	☐	☐	Cancer
☐	☐	Alcohol/drug abuse	☐	☐	HIV/AIDS	☐	☐	Colitis
☐	☐	Angina pectoris	☐	☐	Heart conditions	☐	☐	Diabetes
☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐	Emphysema
☐	☐	Artificial heart valve	☐	☐	Hepatitis a/b/c	☐	☐	Breathing issues
☐	☐	Asthma	☐	☐	High blood pressure	☐	☐	Epilepsy/Seizures
☐	☐	Blood transfusion	☐	☐	Joint replacement	☐	☐	Facial surgery
☐	☐	Fever blisters	☐	☐	Frequent headaches	☐	☐	Kidney problems
☐	☐	Liver disease	☐	☐	Osteoporosis	☐	☐	Pacemaker
☐	☐	Psychiatric problems	☐	☐	STD	☐	☐	Shingles
☐	☐	Sickle Cell	☐	☐	Stroke	☐	☐	Thyroid problems
☐	☐	Tuberculosis	☐	☐	Ulcers	☐	☐	Sinus problems

Name _____Date: _____ DOB: _____

Height _____Weight _ BMI _____ Collar size/Neck circumference _____

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Obstructive Sleep Apnea Questions	**Yes**	**No**
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐
Are you currently being treated for OSA?	☐	☐
Are you aware of a family history of OSA?	☐	☐
Are you aware of clenching or grinding your teeth at night?	☐	☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

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

Situation	**Chance of Dozing**
1. Sitting and reading	
2. Watching TV	
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly in a lunch without alcohol	
8. In a car while stopped for a few minutes in traffic	

STOP - BANG

			Yes	**No**
1.	**S**nore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	☐	☐
2.	**T**ired	Do you often feel tired, fatigued or sleepy during daytime?	☐	☐
3.	**O**bstruction	Has anyone observed you stop breathing during your sleep?	☐	☐
4.	**P**ressure	Do you have or are you being treated for high blood pressure?	☐	☐
5.	**B**MI	Is your body mass index greater than 28?	☐	☐
6.	**A**ge	Are you 50 years old or older?	☐	☐
7.	**N**eck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	☐	☐
8.	**G**ender	Are you a male?	☐	☐