Center for Cosmetic, Implant & Neuromuscular Dentistry

Thank You for Selecting Our Dental Team

To help us meet all your health care needs, please fill out the front and back of this form completely in ink. If you have any questions or need assistance, please ask us, and we will be happy to help.

Patient Information (Confidential)

Patient name: _____ Email: _____
SSN: _____ Birthdate: _____ Home Phone: _____
Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If student, name of school/colle_____ City: _____ State: _____ ☐ Full Time ☐ Part Time
Patient's or parent's employer: _____ Work Phone: _____
Business address: _____ City: _____ State: _____ Zip: _____
Spouse or parent's name: _____ Employer: _____ Work Phone: _____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient: _____
Address: _____ Home Phone: _____
Driver's License #: _____ Birthdate: _____ Financial Institution: _____
Employer: _____ Work Phone: _____ SSN: _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we accept the following methods of payment. Check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ *Credit Card* ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____

4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard
5. Do your gums bleed while brushing? ☐ Yes ☐ No
6. Do your gums bleed when flossing? ☐ Yes ☐ No
7. Do you feel pain in any of your teeth when brushing or flossing them? ☐ Yes ☐ No
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? ☐ Yes ☐ No
9. Have you noticed any loosening of your teeth? ☐ Yes ☐ No
10. Does food tend to get caught between your teeth? ☐ Yes ☐ No
11. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
12. Have you ever experienced any of the following problems in your jaw?
    a. Clicking? ☐ Yes ☐ No
    b. Pain (joint, ear, side of face)? ☐ Yes ☐ No
    c. Difficulty in opening or closing? ☐ Yes ☐ No
    d. Difficulty in chewing? ☐ Yes ☐ No
13. Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No
14. Have you ever fainted? ☐ Yes ☐ No
15. Do you have ringing in your ears (tinnitus)? ☐ Yes ☐ No
16. Do you have frequent headaches or migraines? ☐ Yes ☐ No
17. Do you clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
18. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
19. Have you ever had:
    a. Orthodontic treatment (braces)? ☐ Yes ☐ No
    b. Oral surgery? ☐ Yes ☐ No
    c. Gum treatment? ☐ Yes ☐ No
    d. Your teeth ground or the bite adjusted? ☐ Yes ☐ No
    e. A bite plate or other appliance? ☐ Yes ☐ No
20. Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
21. Have you ever had an upsetting experience in the dental office? ☐ Yes ☐ No
22. Is there anything about having dental treatment that bothers you? ☐ Yes ☐ No

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. Are you in good health? Y☐ N☐
2. Have there been any changes in your general health within the past year? Y☐ N☐
3. Date of your last physical exam: _____
4. Physician's name: _____
   Address: _____
   Phone #: _____
5. Are you now under the care of a physician? Y☐ N☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Y☐ N☐
   Please explain: _____
   _____
7. Are you taking any medication including non-prescription medication? Y☐ N☐
   If yes, what medication are you taking? _____
   _____
8. Have you ever taken appetite suppressants—Fen-Phen (Fenfluramine, Phentermine, Dexfenfluramine, Fenfluramine)? Y☐ N☐
9. Have you had any abnormal bleeding? Y☐ N☐
10. Do you bruise easily? Y☐ N☐
11. Have you ever required a blood transfusion?
12. Have you had a recent weight loss? Y☐ N☐
13. Do you use tobacco? Y☐ N☐
14. Do you use alcohol? Y☐ N☐
15. Do you use controlled substances? Y☐ N☐
16. Do you have any disease, condition, or problem not listed above that you think I should know about? Y☐ N☐

1. Are you pregnant or think you may be pregnant? Y☐ N☐
2. Are you nursing? Y☐ N☐
3. Are you taking brith control pills? Y☐ N☐

Are you allergic to or have you had reactions to:

1. Local anesthetics like novocaine? Y☐ N☐
2. Penicillin or other antibiotics? Y☐ N☐
3. Sulfa drugs? Y☐ N☐
4. Barbiturates, sedatives, or sleeping pills? Y☐ N☐
5. Aspirin? Y☐ N☐
6. Iodine? Y☐ N☐
7. Latex gloves? Y☐ N☐
8. Other? _____

Do you have or have you ever had the following?

1. Rheumatic heart disease or rheumatic fever Y☐ N☐
2. Scarlet fever Y☐ N☐
3. Heart defect or heart murmur Y☐ N☐
4. Heart trouble, heart attack, or angina Y☐ N☐
   a. Do you have pain in your chest upon exertion? Y☐ N☐
   b. Are you ever short of breath after mild exercise? Y☐ N☐
   c. Do your ankles swell? Y☐ N☐
   d. Do you get short of breath when you lie down? Y☐ N☐
   e. Do you require extra pillows when you sleep? Y☐ N☐
5. Pacemaker Y☐ N☐
6. Heart surgery Y☐ N☐
7. High blood pressure Y☐ N☐
8. Low blood pressure Y☐ N☐
9. Hepatitis, jaundice, or liver disease Y☐ N☐
10. Stroke Y☐ N☐
11. Sinus trouble Y☐ N☐
12. Lung or breathing problems Y☐ N☐
13. Asthma or hay fever Y☐ N☐
14. Hives or skin rash Y☐ N☐
15. Fainting spells or seizures Y☐ N☐
16. Diabetes Y☐ N☐
17. AIDS or HIV infection Y☐ N☐
18. Thyroid problems Y☐ N☐
19. Allergies Y☐ N☐
20. Arthritis or rheumatism Y☐ N☐
21. Joint replacement or implant Y☐ N☐
22. Stomach ulcer Y☐ N☐
23. Kidney trouble Y☐ N☐
24. Tuberculosis Y☐ N☐
25. Persistent cough Y☐ N☐
26. Cough that produces blood Y☐ N☐
27. Cancer Y☐ N☐
28. Sexually transmitted disease Y☐ N☐
29. Epilepsy Y☐ N☐
30. Anemia Y☐ N☐
31. Leukemia Y☐ N☐
32. Glaucoma Y☐ N☐
33. Radiation therapy Y☐ N☐
34. Chemotherapy Y☐ N☐
35. Sleep apnea Y☐ N☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Consent:

1. The undersigned hereby authorizes doctor to order 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.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient _____ Date_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

Center for Cosmetic, Implant & Neuromuscular Dentistry

CENTER FOR COSMETIC, IMPLANT, AND NEUROMUSCULAR DENTISTRY

PATIENT CONSENT TO DENTAL TREATMENT

1. EXAMINATION AND X-RAYS

INITIAL _____ I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. DRUGS, MEDICATIONAS AND SEDATION

INITIAL _____ I have been informed and understand that antibiotics and other medication can cause allergic reactions causing redness and swelling of tissue, pain itching, vomiting, and /or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol and other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN

INITIAL _____ I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that wear not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Solomon or his associates to make any/all changes and additions as necessary.

4. TEMPORMANDIBULAR JOINT DYSFUNCTION (TMJ)

INTIAL _____ I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. FILLINGS

INITIAL _____ I have been advised of the need for composite (tooth colored resin), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to natural wearing of the material. In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build up, and crowns), which would necessitate a separate charge. I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and the advantages and disadvantages of alternative material have been explained to me, and I have seen the Dental Materials Fact Sheet. I understand that care must be exercised in chewing on fillings during the first 14 hours to avoid breakage. I understand that sensitivity is common after newly placed fillings.

6. REMOVAL OF TEETH

INITIAL _____ Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dr. Solomon or his associates to remove the following teeth and any others necessary for reasons in paragraph 3. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING

INITIAL _____ I understand that sometimes it is not possible to match the shade of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered or seated. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and shade) will be before final cementation. It has been explained to me that in very few cases, cosmetic procedures may result in the need for future root canal therapy, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES-COMPLETE OR PARTIAL

INITIAL _____ I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit**, size, placement, and shade) will be the "teeth in wax" try** in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for these procedures is not included in the initial denture fee.

9. ENDODONTIC TREATMENT (ROOTH CANAL)

INITIAL _____ I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT

INITIAL _____ I understand that I have a serious condition causing gum inflammation and or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment which I have requested and authorized. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

CENTER FOR COSMETIC, IMPLANT, AND NEUROMUSCULAR DENTISTRY

OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. 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 that you read and sign.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. WE ALSO OFFER CARE CREDIT WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Insurance

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

Payment Plans

Dental Wellness has partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 3, 6, or 12 months with approval. No other payment plans are available.

Missed Appointments /cancelation policy

Unless cancelled at least **48 hours** in advance (two business days' notice), our policy is to charge for missed appointments at the rate of **$75.00**
Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office for a $25 fee.

Billing

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a $30 returned check fee.

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

Patient Signature _____ Date: _____

Acknowledgment of Receipt of Privacy Practices:

I, _____, have received a copy of this office's Notice of Privacy Practices which is in compliance with HIPPA.
Please Print Name

_____ _____
Signature **Date**



NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy policies, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/15/2002 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, or conducting training programs, accreditation, certification, licensing, or credentialing activities.

You Authorization: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity of emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ have received a copy of this offices' notice of privacy practices which is in compliance with HIPAA.

Print name: _____

Signature: _____ Date: _____