Life Enhancing Dentistry

Nadya Aldochine D.M.D.

Date: _____

Patient Name: _____ Single___Married___Widowed___Divorced___

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Birth Date: _____

Employer: _____ Occupation: _____

Business Address:_____

Person Responsible for Account: _____

Do you have dental insurance? _____ Company _____

Member ID#: _____ Subscriber SSN: _____ Insurance Phone Number: _____

How did you hear about us? _____

Whom may we thank for this referral? _____

These are things important to me about my dental health:

1. My mouth is
   A.) very comfortable
   B.) moderately comfortable
   C.) uncomfortable

2. I (I am)
   A.) think the appearance of my mouth is excellent
   B.) satisfied with the appearance of my mouth
   C.) dissatisfied with the appearance of my mouth

3. I
   A.) will do anything to keep my natural teeth
   B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
   C.) don't care whether I keep my teeth or not

4. I
   A.) have set goals for my oral health with a previous dentist
   B.) want to set goals concerning my dental health
   C.) never set goals concerning my dental health

5. I
   A.) have always done the best that was recommended for my dental health
   B.) have not done what dentists have recommended for my mouth
   C.) rarely go, and don't care much about having my dental work completed

6. I have
   A.) put dentistry for myself and my family high on my priority list
   B.) put dentistry for myself and my family low on my priority list
   C.) it's on my list but hard to find

7. I think my present state of dental health is
   A.) excellent
   B.) good
   C.) poor

8. I aspire to have a mouth with
   A.) excellent health
   B.) good health
   C.) poor health

What is/are your primary concerns?

_____

_____

_____

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MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician/ and their specialty: _____ Last physical examination: _____

What is your estimate of your general health? ____ Excellent ____ Good ____ Fair ____ Poor

DO YOU HAVE OR HAVE YOU EVER HAD: **YES NO**

1. Hospitalization for illness or injury _____ ___ ___
2. An allergic reaction to
   - Aspirin, ibuprofen, acetaminophen codeine
   - Penicillin
   - Erythromycin
   - Tetracycline
   - Sulpha
   - Local anesthetic
   - Fluoride
   - Metals (nickel, gold, silver)
   - Latex
   - Other _____
3. Heart problems/ cardiac stent within last 6 months ___ ___
4. History of ineffective endocarditis_____ ___ ___
5. Artificial heart valve, repaired heart defect (PFO) ___ ___ ___
6. Pacemaker or implantable defibrillator _____ ___ ___
7. Artificial prosthesis (heart or valve joints) _____ ___ ___
8. Rheumatic or scarlet fever _____ ___ ___
9. High or low blood pressure _____ ___ ___
10. A stroke (taking blood thinners) _____ ___ ___
11. Anemia or other blood disorder _____ ___ ___
12. Prolonged bleeding sue to slight cute (INR >3.5) ___ ___ ___
13. Emphysema, sarcoidosis _____ ___ ___
14. Tuberculosis _____ ___ ___
15. Asthma _____ ___ ___
16. Breathing or sleep problems _____ ___ ___
17. Kidney disease _____ ___ ___
18. Liver disease _____ ___ ___
19. Jaundice _____ ___ ___
20. Thyroid, parathyroid or calcium deficiency _____ ___ ___
21. Hormone deficiency _____ ___ ___
22. High cholesterol or taking stain drugs _____ ___ ___
23. Diabetes (HbA1c=_____)_____ ___ ___
24. Stomach or duodenal ulcer _____ ___ ___
25. Digestive disorders (i.e. gastric reflux) _____ ___ ___

YES NO

26. Osteoporosis/osteopenia (i.e.take bisphosphonates)___ ___
27. Arthritis _____ ___ ___
28. Glaucoma _____ ___ ___
29. Contact lenses _____ ___ ___
30. Head or neck injuries _____ ___ ___
31. Epilepsy, convulsions (seizures) _____ ___ ___
32. Nuerologic problems (attention deficit disorder) ___ ___ ___
33. Viral infections and cold sores _____ ___ ___
34. Any lumps or swelling in the mouth _____ ___ ___
35. Hives, skin rash, hay fever _____ ___ ___
36. Venereal disease _____ ___ ___
37. Hepatitis (type___) _____ ___ ___
38. HIV/AIDS _____ ___ ___
39. Tumor, abnormal growth _____ ___ ___
40. Radiation therapy _____ ___ ___
41. Chemotherapy _____ ___ ___
42. Emotional problems _____ ___ ___
43. Psychiatric treatment _____ ___ ___
44. Antidepressant medication _____ ___ ___
45. Alcohol/drug dependency _____ ___ ___

ARE YOU

46. Presently being treated for any other illnesses _____ ___ ___
47. Aware of a change in your general health _____ ___ ___
48. Taking medication for weight management _____ ___ ___
49. Taking dietary supplements _____ ___ ___
50. Often exhausted or fatigued _____ ___ ___
51. Subject to frequent headaches _____ ___ ___
52. A smoker or smoked previously _____ ___ ___
53. Considered a touchy person _____ ___ ___
54. Often unhappy or depressed _____ ___ ___
55. FEMALE - taking birth control pills _____ ___ ___
56. FEMALE – pregnant _____ ___ ___
57. MALE – prostate disorders _____ ___ ___

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years.

DO NOT STOP TAKING ANY MEDICATION WHILE YOU ARE UNDER OUR CARE WHICH WAS PRESCRIBED TO YOU BY YOUR PRIMARY CARE PHYSICIAN.

Drug	Purpose	Drug	Purpose

Ask for additional sheet if you are taking more than 6 medications.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____

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DENTAL HISTORY

Previous Dentist: _____ How long have you been a patient? _____

Date of most recent dental exam: ___/___/____ Date of most recent x-rays: ___/___/___

I routinely see my dentist every: ___3 months ___4 months ___ 6months ___ 12 months ___ Not routinely

Please answer yes or no to the following:

PERSONAL HISTORY	**YES**	**NO**
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)? _____	_____	_____
2. Have you had an unfavorable dental experience? _____	_____	_____
3. Have you ever had complications from past dental treatment? _____	_____	_____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	_____	_____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	_____	_____
6. Have you had any teeth removed? _____	_____	_____
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change? _____	_____	_____
8. Have you ever whitened (bleached) your teeth? _____	_____	_____
9. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? _____	_____	_____
10. Have you been disappointed with the appearance of previous dental work? _____	_____	_____
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	_____	_____
12. Do you / would you have any problems chewing gum? _____	_____	_____
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____	_____	_____
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	_____	_____
15. Are your teeth crowding or developing spaces? _____	_____	_____
16. Do you have more than one bite and squeeze to make your teeth fit together? _____	_____	_____
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	_____	_____
18. Do you clench your teeth in the daytime or make them sore? _____	_____	_____
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	_____	_____
20. Do you wear or have you ever worn a bite appliance? _____	_____	_____
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years? _____	_____	_____
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food? _____	_____	_____
23. Do you feel or notice any holes? (i.e. pitting, craters) on the biting surface of your teeth? _____	_____	_____
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	_____	_____
25. Do you have grooves or notches on your teeth near the gum line? _____	_____	_____
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	_____	_____
27. Do you get food caught between any teeth? _____	_____	_____
GUM AND BONE		
28. Do your gums bleed when brushing or flossing? _____	_____	_____
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	_____	_____
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____	_____	_____
31. Is there anyone with a history of periodontal disease in your family? _____	_____	_____
32. Have you ever experienced gum recession? _____	_____	_____
33. Have you ever had teeth become loose on their own (without injury), or do you have difficulty eating an apple?	_____	_____
34. Have you experienced a burning sensation in your mouth? _____	_____	_____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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Assignment and Release

I the undersigned, have insurance with _____, and assign directly to Life Enhancing Dentistry all 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 the payment of benefits.

Date: _____ Signature: _____

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Life Enhancing Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 2-business days prior to my scheduled appointment time. ***For appointments scheduled for 2 hours or longer or an appointment scheduled on a Saturday, I will be required to make a reservation fee of 10% of the total cost of treatment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not keep my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment. **Cancellations with fewer than 48 working hours have a $75 an hour cancellation fee per hour. Patients who are more than 15 minutes late, MAY need to get rescheduled and will also incur a $75 cancellation fee.**

I understand that payment is due at the time of service unless other arrangements have been made. For all with dental benefits, your estimated portion is due at the time of service and as a courtesy we will file a claim with your dental benefit plan. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____

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HIPAA- PATIENT ACKNOWLEDGEMENT FORM

Life Enhancing Dentistry's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Life Enhancing Dentistry to leave a message or an email regarding an appointment at:

Home: _____and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Life Enhancing Dentistry to share medical/dental information with:

1. Name: _____ Relationship: _____

   Phone: _____

2. Name: _____ Relationship: _____

   Phone: _____

3. Name: _____ Relationship: _____

   Phone: _____

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): _____ Date: _____

Signature of Patient or Legal Guardian: _____