DENTAL BOUTIQUE
AESTHETIC COMPREHENSIVE DENTISTRY

Be Our Guest

At the Dental Boutique, we are committed to making sure you feel comfortable and at ease. We believe it is of the utmost importance to build a rapport with each one of our patients. Many patients have had unpleasant experiences while undergoing dental treatment in the past and we want to know if this has been the case for you. Please tell us your fears and concerns so we can do our best to reduce your anxiety and make your experience with us as smooth as possible.

Please check the boxes which describe you most:

- ☐ I gag easily
- ☐ I can't lie down on my back, I would rather be up on an angle as much as possible.
- ☐ I don't like the unknown, I want to know what is going on and what is being done to me.
- ☐ My teeth are very sensitive.
- ☐ I don't think I take care of my mouth the way I am supposed to, I would like to review proper home care but I have been afraid or embarrassed to ask.
- ☐ I have difficulty listening and remembering what I hear while in the dental chair, please review my treatment with my spouse, friend, relative, other.
- ☐ Dental work gives me anxiety, I am very nervous just being here.

Your comfort is our priority. Our office provides a variety of services to ensure that you are comfortable during your visit with us. **Please review the following options:**

Patients find that if they take an analgesic prior to treatment it helps once the anesthesia has worn off. If you are interested in this option, which would you prefer? ☐Tylenol ☐Advil

We provide various levels of sedation to ease your mind. Would you be interested in a sedative?
☐Yes ☐No ~ If yes, we provide: ☐Nitrous Oxide (laughing gas)
☐Mild sedative (oral medication)**

** **Please note, you will need someone to drive you to your appointment.**

Our treatment rooms have cable television. Please let us know what types of programs you prefer to watch, or if there are certain channels you enjoy most.

_____ _____

_____ _____

We provide pillows if you suffer from a sore neck or back. Would you like a pillow? ☐Yes ☐No

Complimentary WiFi Internet access is available for you to use while you are visiting us. Please feel free to bring your iPad, laptop, or other wireless internet device with you for each visit.

Is there anything else we can do to make your visit more comfortable? Please let us know.

_____

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental serviced performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. Any emergency treatment that requires the office to be opened after hours will incur an additional fee of $150.

We respect your time and we hope that you will respect ours and the time of our other patients as well. Please be on time for your appointments so that we can stay on schedule for you and our other patients. **If you must cancel or reschedule, please give at least 24 hours notice.** If a patient is consistently late or consistently breaks appointments, a $50 fee will be incurred.

Patients with dental insurance which this office participates are responsible for for all fees regardless of insurance coverage. This includes any deductibles, copays, denials, and non-covered services. We do our best to estimate what you owe prior to treatment.

Patients with dental insurance which the office does not participate understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will prepare insurance forms or assist in making collections from insurance companies and will credit the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by that insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the fees for services at the time of treatment, or within five (5) days of billing if credit is extended. I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

Signature:_____Date:_____

Consent for Use and Disclosure of Health Information

Patient name: _____ SS#: _____

Address: _____

Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (718) 356-9700 or by mailing us at 5434 Amboy Road, Staten Island, NY 10312.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action we took before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name: _____ Relationship: _____

You are entitled to a copy of this consent after you sign it.

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Dental Health and Appearance

Reason for visit: _____

_____

Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first?_____

_____

_____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐Yes ☐No. If so, explain_____

What, if anything, has happened in previous experiences at the dentist that was reason not to return?

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath?_____

How often do you brush your teeth? ____time(s) a _____ How often do you floss? ____time(s) a _____

What type of brush do you use? ☐Manual ☐Powered

Do you avoid brushing any part of your mouth because of pain? ☐Yes ☐No. If yes, what part?_____

Which foods cause you twinges of pain: ☐Hot ☐Cold ☐Sweet ☐None

Do your gums feel tender or swollen? ☐Yes ☐No

Do you chew on only one side of your mouth? ☐Yes ☐No. If yes, explain: _____

Do you clench or grind your teeth? ☐At night ☐During the day ☐I don't know

Do you wake up with your jaw feeling tired? ☐Yes ☐No. Do you wear a nightguard? ☐Yes ☐No

Cosmetic/ Esthetic Evaluation

Are you happy with your smile? ☐Yes ☐No

Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): _____

If you do not like your smile, please explain why: _____

Would you like to have whiter teeth? ☐Yes ☐No

Would you like to know how we can straighten your teeth without braces? ☐Yes ☐No

If you could have your dream smile, what would you change about yours?_____

Do you have any special occasions coming up? _____

Please add anything you feel is important:

_____

_____

_____

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Registration and Health History

Date: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ ☐Male ☐Female

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Emergency Contact: _____

Email Address: _____

How do you prefer to be contacted? ☐phone ☐email ☐text

Marital Status: ☐Married ☐Single

Student: ☐Full-time ☐Part-time ☐N/A Occupation: _____

What do you prefer to be called? _____

Who may we thank for this referral? _____

Family Physician: _____ Phone #: _____

Dental Insurance Carrier: _____ ID#:_____ Group#: _____

Name of Insured: _____

Insured SS#: _____ Insured's DOB: _____

Relationship to Insured: _____

Employer of Insured: _____ ☐Full-time ☐Part-time ☐Retired

Phone #: _____

Employer Address: _____

City: _____ State:_____ Zip: _____

Who is financially responsible for this account? _____

Please check Yes or No if you have or have a history of being treated for any of the following conditions:

Rheumatic Fever..... ☐Yes ☐No

Heart Disease..... ☐Yes ☐No

Heart Murmur (or MVP)..... ☐Yes ☐No

High Blood Pressure..... ☐Yes ☐No

Tuberculosis..... ☐Yes ☐No

Use Oral Contraceptives..... ☐Yes ☐No

Diabetes..... ☐Yes ☐No

Hepatitis..... ☐Yes ☐No. Type: ☐A ☐B ☐C

Radiation Therapy: Head/Neck..... ☐Yes ☐No

Seizure Disorder..... ☐Yes ☐No

Kidney Disease..... ☐Yes ☐No

Venereal Disease..... ☐Yes ☐No

Artificial Joint/Heart Valve..... ☐ Yes ☐ No

History of Endocarditis..... ☐ Yes ☐ No

Thyroid Disease..... ☐ Yes ☐ No

Anemia..... ☐ Yes ☐ No

Asthma..... ☐ Yes ☐ No

Bleeding Problems..... ☐ Yes ☐ No

Cancer..... ☐ Yes ☐ No

Aids/HIV..... ☐ Yes ☐ No

Eating Disorders..... ☐ Yes ☐ No

Take **bisphosphonates**, such as Fosamax, Actonel, or Boniva..... ☐ Yes ☐ No

Take **aspirin or any blood thinners**, such as Warfarin, Plavix, etc?..... ☐ Yes ☐ No

Is there a chance you may be pregnant?..... ☐ Yes ☐ No Are you nursing?..... ☐ Yes ☐ No

Other conditions not listed: _____

Are you allergic to latex or any other products? _____

List any antibiotics, anesthetics or other drugs you are allergic to _____

_____

_____

List all prescription medications you are presently taking: _____

_____

_____

Have you ever been told you must take an antibiotic prior to dental treatment? ☐ Yes ☐ No

If yes, which one? _____

Have you ever been hospitalized? If so, please explain: _____

Are you presently under a physician's care? ☐ Yes ☐ No

If yes, why? _____

Do you have, or have you ever had clicking popping or pain in your temporomandibular joints (TMJ)?

☐ Yes ☐ No

Have you ever been a drug or substance abuser? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No. If yes, How much? _____

I attest that I understand and have answered all the above questions honestly and completely. I understand that the doctor is basing treatment on this information and that by answering inaccurately could have an affect on treatment outcome or result in complications. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to C&K Dental Boutique unless otherwise indicated.

Signature:_____ Date:_____

To be signed at 6 month recall:

I have reviewed and updated my personal contact information and medical history.

Signature:_____ Date:_____