



Thank you for choosing Arch Dental Associates for your dental care. Our primary mission is to deliver the finest and most advanced dental care available today to enable you to keep your teeth and gums healthy and beautiful throughout your lifetime.

We specialize in caring for our patients. Here at our state-of-the-art office you will experience gentle and professional care you have been looking for. Whatever your dental needs may be, we can satisfy them within the confines of our office. We are here to assist you with any questions you may have concerning any aspect of your dental treatment.

For your convenience, we have enclosed a health history form, notice of privacy practices and our financial policy. Please complete the health history form and bring it with you on your visit with us. If you have any questions or would like to discuss the financial options available to you, please feel free to call us.

We welcome you in joining our family of patients and look forward to caring for you!

FROM ALL OF US..... WELCOME!



Arch Dental Associates

Patient Information

Patient Name: _____ Date: _____
Last First MI

How would you prefer our staff to address you? _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cellular: _____

Email: _____

Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Latex Sensitivity |
| <input type="checkbox"/> Glaucoma | Due date: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Radiation Treatment | _____ |
| | <input type="checkbox"/> Respiratory Problems | _____ |

Are you allergic to or have you had a reaction to:

- Local anesthetics ___
 Aspirin ___
 Codeine, valium or other sedatives? ___
 Are you taking Tagamet? (Cimetidine) ___
 Do you take Antacids? _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
Are you taking any medication? _____ If so, what? _____
- Have you ever needed to take antibiotic prior to dental treatment? _____
If yes, please explain: _____

Oral Health History

When was your last dental exam? Were x-rays taken? _____

How often do you have your teeth professionally cleaned? _____ When was the last time? _____

Name and address of former dentist(if any) _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Orthodontic treatment? Periodontal treatment? Endodontic treatment? _____

Please specify _____

Are your teeth sensitive to cold, hot, sweets or pressure?(specify) _____

Does your bite feel uncomfortable? _____

Do you avoid part of your mouth while eating, chewing or biting?(specify)

Do your gums bleed? If so, for how long have you had this? _____

Have you ever had acute or painful gum infections, swelling, tenderness or irritation of the gum tissue?

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAD:

- | | |
|--|---|
| <input type="checkbox"/> bad breath | <input type="checkbox"/> history of TMJ-pain or clicking jaw |
| <input type="checkbox"/> burning of tongue | <input type="checkbox"/> oral habits, ie. Fingernail biting |
| <input type="checkbox"/> clenching or grinding of teeth | <input type="checkbox"/> pain or ringing in ear while chewing |
| <input type="checkbox"/> food impaction | <input type="checkbox"/> swelling or lumps in mouth, on lips |
| <input type="checkbox"/> frequent blisters, canker sores, or cold sores on lips or mouth | <input type="checkbox"/> unpleasant taste in mouth |

How often do you BRUSH? _____ FLOSS? _____

What kind of toothbrush and dentifrice do you use? _____

Do you use a waterjet device? _____

Do you use fluoride supplements? _____

NUTRITION

Do you eat well balanced meals? _____

Do you eat in between meal snacks? _____

Do you eat red meat? How often? _____

Do you eat sugar on a daily basis? Candy? Gum? Soda? _____

Do you drink coffee or tea? How much daily? _____

Do you smoke cigarettes, pipes, or cigars? How much daily? _____

Are you satisfied with the appearance of your smile? _____

Please let us know how we can help you be satisfied with your mouth and achieve a sense of oral well being? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a full notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½ % late charge (18% APR) may be added to my account. If requires, I also understand a check of my credit history may be made.

Patients Signature _____ Date _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper L.I./N.Y. Naturally Creations L.I. Voices
 Pennysaver Nursery School Internet Radio, which station? _____
 1-800- DENTIST Other _____

Name of person or office referring you to our practice: _____

May we have your permission to thank the person who referred you? _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Last First MI ID #: _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Last First MI ID #: _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____



Arch Dental Associates

SMILE EVALUATION

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire. While using a mirror or looking at a photograph, please observe your teeth carefully.

- 1) Do you have any concerns about bad breath odor?

- 2) Are you pleased with the appearance of your teeth when you smile?

- 3) Are you pleased with the color of your teeth?

- 4) Are you pleased with the shape of your teeth?

- 5) Are there spaces between your teeth that you don't like?

- 6) Are your teeth...
chipped? _____ protruding? _____ hidden? _____ crowded? _____
- 7) Do you like the way your teeth fit together when you bite?

- 8) Are there old fillings or dental treatment that you aren't happy with?

- 9) If you could change anything about the appearance of your smile, what would that be?

- 10) Is there anything about the shape or alignment of your jaws that you are not happy with?
