



THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

DATE _____

NO CHANGES

First Name _____ Last Name _____

Birth date _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed Domestic Partnership

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY (or select) SELF

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birth date _____ Cell Phone _____ Work Phone _____

Is This Person Currently a Patient in Our Office? Yes No

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

Please select the following

- | | |
|---|---|
| 1. Do your gums bleed while brushing? Y <input type="checkbox"/> N <input type="checkbox"/> | 8. Do you have frequent headaches? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/food? Y <input type="checkbox"/> N <input type="checkbox"/> | 9. Do you clench or grind your teeth? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/food? Y <input type="checkbox"/> N <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? Y <input type="checkbox"/> N <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? Y <input type="checkbox"/> N <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? Y <input type="checkbox"/> N <input type="checkbox"/> | 13. Have you had any orthodontic treatment? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? Y <input type="checkbox"/> N <input type="checkbox"/> | 14. Do you wear dentures or partials? Y <input type="checkbox"/> N <input type="checkbox"/> |
| Clicking Y <input type="checkbox"/> N <input type="checkbox"/> | If yes, date of placement _____ |
| Pain (joint, ear, side of face) Y <input type="checkbox"/> N <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Y <input type="checkbox"/> N <input type="checkbox"/> |
| Difficulty in opening or closing Y <input type="checkbox"/> N <input type="checkbox"/> | 16. Do you like your smile? Y <input type="checkbox"/> N <input type="checkbox"/> |
| Difficulty in chewing Y <input type="checkbox"/> N <input type="checkbox"/> | |

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

List of Specialists you see (i.e. Chiropractor, Herbalist, etc.)

Name _____ Office Phone _____ Date of Last Exam _____

Name _____ Office Phone _____ Date of Last Exam _____

List of supplements you currently take:

1. Are you under medical treatment now?

Y N

2. Do you wear contact lenses?

Y N

3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?

Y N

If yes, please explain _____

4. Are you taking any medications including non-prescription medications? Y N

If yes, what medications are you taking? _____

5. Have you ever taken Fen-Phen/Redux? Y N

6. Do you use controlled substances? Y N

7. Do you use Tobacco products? Never Yes No, but have in the past

Please select any of the conditions you have or have had in the past. If none of the following apply, please select "none of the above." Under allergies, please check the following you are allergic or have had any reactions to.

CONDITIONS

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Angina | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Replacement or Implant |
| <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Stomach Troubles/Ulcers | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> Other _____ | | |

ALLERGIES

- | |
|---|
| <input type="checkbox"/> Local Anesthetics (e.g. Novocain) |
| <input type="checkbox"/> Penicillin or any other Antibiotics |
| <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Any Metals
(e.g. nickel, mercury, etc.) |
| <input type="checkbox"/> Latex Rubber |
| <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> NONE OF THE ABOVE |

Notes: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date _____
Signature of patient (or parent/guardian if minor)



Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (PRINT) have read the office's Notice of Privacy Practices. I also understand that Dr. Alla Aver may contact my doctor (MD) and/or therapist involved in my care as necessary.

**Please see front desk if you would like a copy for your records.*

Signature

Date

If there are specialists you would like Dr. Alla Aver DDS to communicate with in addition to your primary health care provider, please list them here.

PLEASE NOTE: You may refuse to sign this acknowledgment

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify):



Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental “clinic.” Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Morning appointments are best for complicated procedures.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be as understanding of the emergency situation. At some point, they may need the same courtesy too.

Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office.

There will be a charge of \$50* for a broken appointment or cancellation with less than 48 hours notice.

NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY.

I have read and understand the Cancellation and No Show Policies of the practice and I agree to the terms.

Name of Patient

Relationship to Patient (if minor)

Signature of Patient or Responsible Party

Date

**All cancellation fees are to be paid prior to scheduling another appointment; therefore we request a credit card for our file.*



Dental Insurance Coverage

Responsibility for Payment

Your employer, management, or union has purchased dental insurance coverage from a selection of plans offered by an insurance company or broker. Each insurance company offers many different plans.

The fees charged for dental treatment reflect the many different parts of a particular procedure of procedures. Treatment for your particular needs may or may not fall within the limits set by your particular dental plan. Many dental procedures may not even be listed in your insurance's procedure/payment schedule. If your dental procedure falls into this category, you may not receive any insurance reimbursement for that procedure. **You are ultimately responsible for paying the entire fee for an accepted dental treatment, regardless of your insurance coverage.**

Choosing Treatment Options

Our goal through your examination, diagnosis, and treatment phases is to provide you with the best possible oral health. We do not allow the insurance company to tell us how to treat you. We recommend to you those treatments that we believe you need and we will discuss alternative plans with you. Whether or not the recommended treatment is a covered dental benefit is between you and your employer and the insurance carrier.

Submitting the Claim

We are happy to help you receive the maximum benefits you are allowed from your dental coverage. In order for us to submit your insurance claim, we will need an insurance form with your portion completed and signed. We deal with dental insurance companies on a daily basis; therefore, we have a great deal of experience submitting these claims to insurance carriers. We take great care in submitting claims properly the first time.

There are three things we CANNOT do:

- 1.) Alter the date of treatment
- 2.) Submit a claim for more than the actual fee
- 3.) Submit a claim for procedures that have not been performed

Because it is not at all uncommon for the insurance carriers to make a mistake, we would prefer to submit the claims ourselves, and then verify proper payment.

Our office cannot negotiate with your insurance company for reimbursement of dental expenses. Only the purchaser of the plan (you employer) can negotiate better coverage. If you would like better or more coverage, you will need to talk with your plan purchaser about the features you want in your dental plan.

If you have any questions about your dental insurance coverage, please feel free to ask us.

Name (Print & Sign)

Date



Ozone Consent Form

Dental oxygen/ozone has been shown to be an effective anti-bacterial, anti-fungal and anti-viral treatment agent by creating a therapeutic oxygen rich environment. It increases circulation, oxygenation to the treatment area and immune response. It creates an environment for the production of anti-oxidants. It is a circulatory stimulant, a wound-cleanser, an accelerant for wound healing, and a haemostatic agent.

I understand with any treatment, there is no guarantee that I will obtain satisfactory results with dental ozone. I may achieve great results, no results, satisfactory results, or unsatisfactory results with dental ozone.

I understand that Dr. Aver uses ozonated water in dental water lines instead of harmful chemicals for all her patients as a pretreatment at no charge. I understand ozone will not affect by my course of treatment in any way.

Ozone/ oxygen therapy could be useful to

1. Kill pathogenic bacteria on the surface of the tooth to allow enamel to re-mineralize naturally.
2. Kill pathogenic bacteria to disinfect deep gum pockets to allow body to build bone around teeth.
3. Kill the bacteria, clean the tooth before the filling is put in, especially in the deep areas.

I understand that Dr. Aver will not administer the ozone/oxygen therapy without informing me about the procedure. I do not represent a third party. I am aware that I may withdraw this consent at any time.

Patient Name

Signature (Parent/Legal Guardian if Minor)

Date