Norwalk
DENTAL CARE

Gregory D. Prieston, DDS PC • 5 Eversley Avenue • Norwalk, CT 06851 • 203-853-6626 • www.norwalkdentalcare.com

REGISTRATION AND HEALTH HISTORY

Date: _____

First Name: _____ M.I. ____ Last Name: _____ ☐ male ☐ female Date of Birth: _____ Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____

Email Address: _____ Emergency Contact: _____

Marital Status: ☐ married ☐ single Student: ☐ full-time ☐ part-time ☐ N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Family Physician: _____ Phone#: _____

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

☐ Check this box *ONLY* if the Insured person *(the person receiving dental service)* is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS#: _____ Insured's Date of Birth: _____

Relationship to Insured: _____

Employer of Insured: _____ ☐ full-time ☐ part-time ☐ retired Phone#: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Who is financially responsible for this account? _____ Phone#: _____

Please select Y =Yes or N= No if you have any of the following conditions:

☐Y ☐N - Rheumatic Fever
☐Y ☐N - Heart Disease
☐Y ☐N - Heart Murmur (or MVP)
☐Y ☐N - High Blood Pressure
☐Y ☐N - Tuberculosis
☐Y ☐N - Use Oral Contraceptives
☐Y ☐N - Artificial Joint / Heart Valve
☐Y ☐N - History of Endocarditis

☐Y ☐N - Thyroid Disease
☐Y ☐N - Anemia
☐Y ☐N - Asthma
☐Y ☐N - Diabetes
☐Y ☐N - Are you nursing
☐Y ☐N - Might you be pregnant
☐Y ☐N - Hepatitis Type: ○ A ○ B ○ C
☐Y ☐N - Radiation Therapy: Head / Neck

☐Y ☐N - Seizure Disorder
☐Y ☐N - Kidney Disease
☐Y ☐N - Venereal Disease
☐Y ☐N - Bleeding Problems
☐Y ☐N - Cancer
☐Y ☐N - Aids/HIV
☐Y ☐N - Eating Disorders

Other conditions not listed: _____

Are you allergic to latex, soy or egg products? _____

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

List all prescription medications you are presently taking: _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

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

Have you been hospitalized in the past five years? ☐ Yes ☐ No If yes, why? _____

Do you take aspirin on a daily basis? ☐ Yes ☐ No If yes, why? _____

Are you under a physician's care presently? ☐ Yes ☐ No If yes, why? _____

Have you ever been a drug or substance abuser? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. 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 unless otherwise indicated.

Signature: _____ Date: _____

Your signature indicates you have received a copy of the HIPAA law and Dental Material forms as well as releasing Dr. Prieston to utilize any dental photographs for lecturing or educational purposes.

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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? _____

When would you like us to start treatment? _____

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 ☐ Sour ☐ 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 jaws while sleeping or during the day? ☐ Yes ☐ No Do your jaws ever feel tired? ☐ Yes ☐ No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? ☐ Yes ☐ No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome) _____

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

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight... Using Dental Imaging and Digital Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? ☐ Yes ☐ No **If yes, please select all that apply:**

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

At Norwalk Dental Care, though our focus is on appearance-related dentistry, our team also delivers routine general dental care as well. With flexible payment plans as well phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm Regards,

Gregory Prieston, D.D.S

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: Telephone: Social Security#:

Address: _____ City: _____ _____ State: _____ _____ Zip: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will 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 whether 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, which will contain the changes. 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 203-853-6626 or by mailing us at 5 Eversley Avenue, Norwalk, Ct 06851.

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 your 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 health care 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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5 Eversley Avenue ◆ Norwalk, CT 06851 ◆ (203) 853-6626

PAYMENT OPTIONS FOR OUR PATIENTS

For Optimum Health and Healthy Smiles

We believe it is important not only to provide the highest quality dental care, but to make this care affordable for our patients. Please ask us any question you may have. We are glad to be of assistance. We have made arrangements for our patients that allow payment to be convenient and flexible. We are committed to helping you receive the dental care you desire and the most pleasant dental experience possible.

1. **Payment in full at visit** with cash, check, or credit card (VISA, MasterCard, Discover or American Express)
   For amounts over $500, we offer a **5% courtesy** for payment in full when you receive treatment. We will gladly process any insurance claim for your direct reimbursement.
   Adjusted fee: $_____(savings: $_____)

2. **Estimated co-payment at visit** with cash, check, or credit card (VISA, MasterCard, Discover or American Express) with most insurance plans following benefit verification.
   Estimated co-payment: $_____
   Please be aware that we cannot guarantee this estimate and that there may be a balance after insurance pays. Whenever choosing this option, we ask that you leave a credit card on file for any balance that may be owed.
   NOTE: Please see the form entitled, "Financial Agreement Pre-Authorization Form"

3. **No- or low-interest payment plans** for amounts over $300 through CareCredit . We will gladly process any insurance claim for your direct reimbursement.
   Monthly payment: $_____

   Credit Report Authorization: I, _____ authorize Dr. Prieston to obtain my credit report in the event that I request a payment plan for my treatment.

_____ _____
Patient Signature/Guardian Signature Date

Note to patients with insurance

We are happy to process any insurance claim as a service to you at no charge. Please keep in mind that any estimate that we provide to you is only an estimate and that you are responsible for all fees in their entirety. We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules, and are often above insurance allowances. You are fortunate to have dental insurance that may help you with the cost of treatment. You may wish to complain to your company's benefits representative should your benefits be less than you expected.

_____*I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).*

Delinquent accounts

Your account is considered delinquent if the requested payment is not received by the tenth (10th) of the month. If payment is not received, a late charge of 1 ½% per month ($1.00 minimum) will be assessed. The annual percentage rate is 18%.If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I have read and understand the financial options of Dr. Prieston and agree to the terms described in it.

_____ _____
Patient Signature/Guardian Signature Date

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COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
  Which would you prefer? ☐ Tylenol ☐ Advil ☐ Other: _____

- We provide various levels of sedation to ease your mind.
  Would you benefit from a sedative? ☐ Yes ☐ No

  If yes, we provide: ☐ Nitrous Oxide (laughing gas)
  ☐ Mild sedative (oral medication
  (Note: With mild sedative, you will need someone to drive you to the appointment.)

- We now offer Oraverse, Oraverse is the first and only product to rapidly reverse the effects of your local dental anesthetic.
  Would you be interested in learning more about it? ☐ Yes ☐ No

- Our treatment rooms are equipped with cable TV and DVD players. Watching TV or a movie is an excellent way to pass the time during your visit. Please let us know what your favorite movie or TV shows are, and at your next appointment we will make sure we have it for you to watch.

_____

- We also have iPods for your use with personalized playlists.
  Would you like to use an iPod during your visits? ☐ Yes ☐ No
  Please provide a list of the artists or type of music you like so we can load them for your next visit.

_____

- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.
  Would you like a blanket? ☐ Yes ☐ No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
  Would you like a pillow? ☐ Yes ☐ No

- We also offer our patients a complimentary paraffin wax treatment during your visit.
  Would you like to take advantage of this service? ☐ Yes ☐ No

- Is there anything else we can do to make your visit comfortable?

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Please Handle Me With Care

_____
Patient Name

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down for a long time, and I feel uncomfortable about what you will say about my teeth and hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I am interested in conscious sedation (nitrous oxide with oxygen)
  (Commonly called laughing gas, produces a mild sedation that is helpful in decreasing anxiety.)
- ☐ I am interested in oral sedation: for adults who need a deeper state of sedation

Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me, how each dental procedure will work, and how much of my time will be required.