New Patient Information

We are committed to excellence in dentistry and appreciate your taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us – we will be happy to help.

How did you hear about our office? _____ Today's Date: _____

ABOUT YOU

Name: _____ I prefer to be called: _____ ( )M ( )F

( ) Single ( ) Married ( ) Life Partner ( ) Child DOB: _____ SS#: _____

Address: _____ City: _____State: _____Zip: _____

Home #: _____ Cell #: _____

E-mail: _____ Driver's Lic. #: _____

Employer: _____Occupation: _____ Tel. #: _____

PERSON RESPONSIBLE FOR ACCOUNT

( ) Same as above
Name: _____ DOB: _____ Relation: _____

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

Home #: _____ Cell#: _____ SS#: _____

Employer: _____ Occupation: _____ Tel. #: _____

SPOUSE INFORMATION

Name: _____ DOB: _____

Cell #: _____ E-mail: _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name: _____Phone #: _____ Group/Policy #: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SS #: _____ Insured's Employer: _____

Secondary Insurance
Insurance Co. Name: _____Phone #: _____ Group/Policy #: _____

Insured's Name: _____ Insured's DOB: _____
Insured's SS #: _____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone #: _____

Do you have or have ever had any of the following? Please check those that apply:

( ) Allergies/Hay Fever	( ) Diabetes	( ) Heart Surgery *	( ) Rheumatic Fever
( ) Anemia	( ) Epilepsy or Seizures	( ) Hepatitis	( ) Rheumatism
( ) Angina	( ) Excessive Thirst	( ) High Blood Pressure	( ) Sickle Cell Disease
( ) Arthritis	( ) Fainting or Dizziness	( ) HIV*/AIDS	( ) Sinus Problems
( ) Artificial Joints*	( ) Fever Blisters/Cold Sores	( ) Kidney Problems	( ) Stroke
( ) Artificial Heart Valves*	( ) Frequent Cough	( ) Liver Problems	( ) Surgical Shunt*
( ) Asthma	( ) Glaucoma	( ) Mental Disorders	( ) Thyroid Problems
( ) Breathing Problems	( ) Heart Disorder (Congenital) *	( ) Mitral Valve Prolapse*	( ) Tuberculosis
( ) Cancer	( ) Heart Infection*	( ) Osteoporosis	( ) Ulcers
( ) Chemical Dependency	( ) Heart Murmur*	( ) Radiation Treatment	( ) Venereal Disease
( ) Chemotherapy	( ) Heart Pace Maker*	( ) Respiratory Problems	( ) Yellow Jaundice

*This condition may require antibiotic premedication for certain dental procedures

Yes No

( ) ( ) Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

( ) ( ) Are you under the care of a physician?
If yes, explain: _____

( ) ( ) Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

( ) ( ) Are you taking any medications or herbals?
If yes, list: _____

( ) ( ) Are you allergic to any medications or substances?
If yes, please check box below:
( )Aspirin ( )Penicillin ( )Codeine ( )Iodine ( )Metal ( )Latex ( )Other: _____

( ) ( ) Have you used tobacco?
If yes, explain: _____

WOMEN (Please check): ( ) Pregnant ( ) Trying to get pregnant ( ) Nursing ( ) Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform Dr. Satvat and her staff at the next appointment without fail.

X_____ Date: _____

Signature of patient, parent or guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date:	Exceptions:		Signature:
_____	_____	( )None	x:_____
_____	_____	( )None	x:_____
_____	_____	( )None	x:_____
_____	_____	( )None	x:_____

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or cast of your teeth to further evaluate areas of concern.
Once all your records have been completed they will be carefully evaluated to determine your current level of dental health. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions. (check the best answer):

1. When was last time you saw a dentist: _____Last dental cleaning: _____
2. Have you had a full mouth set of x-rays (other than routine cavity detection x-rays) within the last 3 years? ( )**Yes** ( )**No**
3. Are your teeth sensitive to ( )**Hot** ( )**Cold** ( )**Sweets**
4. Have you noticed any ( )**bad odors** or ( )**bad tastes** in your mouth? ( )Yes ( )No
5. Does food tend to become caught in between your teeth? ( )Yes ( )No
   If yes, explain where: _____
6. I have a ( )**low** ( )**moderate** ( )**high** fear of going to the dentist.
7. My mouth and teeth are ( )**very** comfortable ( )**moderately** comfortable ( )**not** comfortable.
8. I am ( )**very satisfied** ( )**satisfied** ( )**dissatisfied** with the appearance of my teeth.
9. I think my present state of dental health is ( )**excellent** ( )**good** ( )**fair** ( )**poor**.
10. I would say that my main concerns with my dental health are: _____
11. I am interested in a smile evaluation and personalized treatment plan to enhance my smile ( )Yes ( ) No
12. Have you ever had a bad dental experience? ( )Yes ( ) No
    If yes, explain: _____
13. Please check which statement below best represents the level of dental health you wish to achieve.
    (*Some people begin at one level and progress to a higher level over time.*)

( ) HEALTH LEVEL A – Comprehensive & Cosmetic Care

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.
I am concerned about treating the causes of dental diseases, not simply the effects.
I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

( ) HEALTH LEVEL B – Comprehensive Care

I am interested in comprehensive care to achieve and maintain a higher level of dental health.
I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

( ) HEALTH LEVEL C – Maintenance Care

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

( ) HEALTH LEVEL D – Emergency Care

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.
I am not very interested in thinking about the future of my teeth at this time.

APPOINTMENT & CANCELLATION POLICY

We value your time so you can expect us to see you at the appointed time and keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved the time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use the time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.
A minimum of 48 hours notice is necessary if rescheduling. To change a Tuesday appointment we need to be notified on Thursday since we are closed Fridays. Any notice given less than 48 hours will be charged at $100 per hour of your scheduled appointment time.
A minimum of 2 days is necessary for confirming appointments. If you do not confirm your appointment it may be given away to someone else. ALL APPOINTMENTS MUST BE CONFIRMED.
As a courtesy all appointments may receive an email, text message, phone call or all of the above.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. For your convenience we accept Cash, Check, Visa, Master Card, Amex & Discover. We also have 6 month interest free payment plan through Care Credit . (Extended payment plans also available)
We are in network with most PPO Insurances + Delta Care HMO. Should a patient have dental insurance we are not in network with, we will gladly submit all claims on the patients behalf and ask the insurance provider to mail a reimbursement check to patient directly, therefore, you are responsible for full payment of services rendered.

AUTHORIZATION & CONSENT

General Consent to Treatment

I agree and consent to a dental examination and/or treatment by Dr. Satvat. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedure or dental treatment performed.

Release of Information

I authorize Dr. Satvat to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Photography Release

I authorize Dr. Satvat to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize her to show these photographs to other patients to better explain their treatment options.

We ask you kindly to turn OFF all cell phones while in the office. Initials: _____ Thank you for your understanding.

I understand and will comply with the office **Appointment & Cancellation Policy**
I understand and will comply with the office **Financial Policy**
I understand and agree to the **General Consent to Treatment**
I authorize the **Release of Information** to insurance companies and other doctors.
I authorize **Photographs** to be taken of me and shown to other patients.

X_____ Date: _____
Signature of patient, parent or guardian