THANK YOU FOR SELECTING OUR DENTAL TEAM

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

PATIENT INFORMATION (CONFIDENTIAL)

Patient Number_________________________________

First Name_______________________________________ Last Name ____Date____________________

Birth date_________________________ Home Phone_____________________________ Cell Phone____

Address____ City______________________ State______________ Zip____________________

Email____

Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □Widowed

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

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

INSURANCE INFORMATION

Name of Insured____ Relationship to Patient________________________

Birthdate_____________________ Grp#____ Policy ID#____

PATIENT DENTAL HISTORY

Name of Previous Dentist____Date of Last Exam_________________________________

Previous Dentist's Location____Date of Last Cleaning_____________________________

Please check Yes or No.

1. Do your gums bleed while brushing? Y□ N□
2. Are your teeth sensitive to hot or cold liquids/food? Y □ N□
3. Are your teeth sensitive to sweet or sour liquids/food? Y□ N□
4. Do you feel pain to any of your teeth? Y□ N□
5. Do you have any sores or lumps in or near your mouth? Y□ No□
6. Have you had any head, neck or jaw injuries? Y□ N□
7. Have you ever experienced any of the following problems in your jaw? Y□ N□
   - Clicking Y□ N□
   - Pain (joint, ear, side of face) Y□ N□
   - Difficulty in opening or closing Y□ N□
   - Difficulty in chewing Y□ N□
8. Do you have frequent headaches? Y□ N□
9. Do you clench or grind your teeth? Y□ N□
10. Do you bite your lips or cheeks frequently? Y□ N□
11. Have you ever had any difficult extractions in the past? Yes□ No□
12. Have you ever had any prolonged bleeding following extractions? Y□ N□
13. Have you had any orthodontic treatment? Y□ N□
14. Do you wear dentures or partials? Y□ N□
    If yes, date of placement_________________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Y□ N□
16. Do you like your smile? Y□ N□

Over Please

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____________________

Name________________________ Office Phone__________________ Date of Last Exam____________________

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	Yes	No
1. Are you under medical treatment now?	Y□	N□
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	Y□	N□
If yes, please explain_________________________		
3. Are you taking any medications including non-prescription medications?	Y□	N□
If yes, what medications are you taking? __________		
4. Have you ever taken Fen-Phen/Redux?	Y□	N□

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

	Yes	No
6. Do you use controlled substances?	Y□	N□
7. Do you wear contact lenses?	Y□	N□

9. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (e.g. Novocain)	Y□	N□
Penicillin or any other Antibiotics	Y□	N□
Sulfa Drugs	Y□	N□
Barbiturates	Y□	N□
Sedatives	Y□	N□
Iodine	Y□	N□
Aspirin	Y□	N□
Any Metals (e.g. nickel, mercury, ect.)	Y□	N□
Latex Rubber	Y□	N□

Other______________________________________

List of supplements you currently take:

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Do you have or have you had any of the following?

High Blood Pressure	Y□	N□	Heart Disease	Y□	N□	Chest Pains	Y□	N□
Heart Attack	Y□	N□	Cardiac Pacemaker	Y□	N□	Easily Winded	Y□	N□
Rheumatic Fever	Y□	N□	Heart Murmur	Y□	N□	Stroke	Y□	N□
Swollen Ankles	Y□	N□	Angina	Y□	N□	Hay Fever/Allergies	Y□	N□
Fainting/Seizures	Y□	N□	Frequently Tired	Y□	N□	Tuberculosis	Y□	N□
Asthma	Y□	N□	Anemia	Y□	N□	Radiation Therapy	Y□	N□
Low Blood Pressure	Y□	N□	Emphysema	Y□	N□	Glaucoma	Y□	N□
Epilepsy/Convulsions	Y□	N□	Cancer	Y□	N□	Recent Weight Loss	Y□	N□
Leukemia	Y□	N□	Arthritis	Y□	N□	Liver Disease	Y□	N□
Diabetes	Y□	N□	Joint Replacement or Implant	Y□	N□	Heart Trouble	Y□	N□
Kidney Diseases	Y□	N□	Hepatitis/Jaundice	Y□	N□	Respiratory Problems	Y□	N□
AIDS or HIV Infection	Y□	N□	Sexually Transmitted Disease	Y□	N□	Mitral Valve Prolapse	Y□	N□
Thyroid Problems	Y□	N□	Stomach Troubles/Ulcers	Y□	N□	Other________________		

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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 received a copy and have read the office's Notice of Privacy Practices. I also understand that Dr. Alla Aver my contact Doctors and/or Therapist involved in my care as necessary.

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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.

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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):

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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 ~~is~~ 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.

Ozone Therapy

If I choose Ozone Therapy for a treatment, I understand that insurance companies do not pay for therapeutic usage of the ozone. Pricing is as follows:

1. Kill bacteria to allow enamel to re-mineralize - $45 per tooth
2. Kill bacteria to disinfect deep gum pockets around teeth -$45 per tooth
3. Clean the tooth during filling preparation - $35 per tooth
4. Complete ozone gum treatment (includes trays and 2 full ozone treatments) - $450 per arch

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