How were you referred to this office _____ Social Security # _____Today's Date_____

Patient's Name _____ Birthdate _____

Social Security #_____

Address _____ City _____ ST____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ E-Mail _____

Employer _____ City _____ Occupation _____

Name of Parent /Partner/ Spouse / Guardian _____ Birthdate_____
(circle one)

Social Security #_____

Address if different_____ City_____ ST_____ ZIP _____

Home Phone _____ Work Phone_____ Ext_____

Cell Phone _____ E-Mail _____

Employer _____City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____ Phone _____

DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME_____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP_____

INSURANCE PHONE _____

GROUP / POLICY # _____

SUBSCRIBER ID # _____

BIRTHDATE _____

DENTAL INSURANCE INFORMATION

EMPLOYEE NAME_____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

SUBSCRIBER ID # _____

BIRTHDATE _____

Patient Acknowledgments:

- I understand that all charges incurred are payable in full at the time of service.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist for educational purposes.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor

PATIENT INFORMATION

PATIENT'S NAME _____ DATE OF BIRTH _____

PHYSICIAN'S NAME _____ PHYSICIAN'S ADDRESS _____ PHYSICIAN'S PHONE _____

MOST RECENT VISIT TO PHYSICIAN _____ REASON _____

HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? 0 GOOD 0 FAIR 0 POOR

OFFICE USE ONLY

	YES	NO
PRE-MED	0	0

COMMENTS:

DATE _____

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
Are you currently seeing a physician for treatment of a recent or ongoing medical condition?	0	0
Have you been hospitalized within the last year? If yes, explain:	0	0
Have you had a serious illness or operation within the last year? If yes, explain:	0	0
Have you ever had any serious medical trouble Associated with any dental experience? If yes, explain:	0	0
Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	0	0

Do you now or have you had any of the following cardio-vascular diseases? **yes** 0 **no** 0

If yes, check any that apply:

0 Heart disease
0 Heart attack
0 Coronary bypass
0 Angina
0 Mitral valve prolapse
0 Hardening of the arteries
0 High blood pressure
0 Stroke
0 Heart murmur
0 Congestive heart failure

0 Rheumatic fever or rheumatic heart disease
0 Congenital heart defects
0 Prosthetic (artificial) heart valves
0 Pacemaker. If yes, date of placement _____
0 High blood pressure
0 High cholesterol
0 Shortness of breath after mild exercise
0 Shortness of breath when you lie down
0 Swelling of ankles

Diabetes **yes** 0 **no** 0

If yes, do you require insulin?
Type _____ Dose_____

Artificial joint(s) **yes** 0 **no** 0

If yes, which joint(s)
_____

Hepatitis **yes** 0 **no** 0

If yes, check type:
0 Type A
0 Type B
0 Type C
0 Other
0 Non-specific type
0 Don't know

0 Required a blood transfusion
If yes, when _____

0 HIV positive
0 Have reason to suspect you have been exposed to the HIV virus

Tuberculosis (TB) **yes** 0 **no** 0

0 Had a TB test?
0 A cough lasting more than three weeks
0 Cough up blood

Check any that apply;

0 Allergies
0 Alzheimer's
0 Anemia
0 Angina
0 Asthma
0 Arthritis
0 Autoimmune
0 Blood Disorder
0 Cancer
0 Chemo Therapy
0 Chronic Sinus
0 Cirrhosis
0 Depression
0 Glaucoma
0 Heart Disease
0 Herpes
0 HIV / AIDS
0 Jaundice
0 Joint Replacement
0 Kidney Disease
0 Organ Transplant
0 Osteoporosis
0 Parkinson's
0 Radiation
0 Treatment
0 Severe Headaches

HEALTH HISTORY

Over Please →

	Yes	No
Do you consider yourself currently under an *abnormally* high amount of stress?	0	0
Have you had an unexplained or unplanned weight loss recently?	0	0

When was your last complete physical exam with your physician, including blood tests? _____

Do you now or have you ever smoked?	0	0

If you currently smoke, how much? _____
If you were a smoker, when did you quit? _____

Do you chew tobacco?	0	0

If yes, how often? _____

Do you drink alcohol?	0	0

W O M E N O N L Y

	Yes	No
Are you currently pregnant?	0	0

If yes, expected delivery date _____

Do you have regular gynecological checkups?	0	0
Have you reached menopause?	0	0
Are you on hormone replacement therapy?	0	0
Have you had a mammogram?	0	0

Date _____

If you *currently* take these medications, check the box on the left. If you have taken any of these medications within the <u>past year</u>, but are not taking them currently, check the box on the right.

o Antibiotics	o
o Antidepressants (Prozac, Zoloft, etc.)	o
o Antihistamines	o
o Blood pressure medication	o
o Blood thinners	o
o Cortisone (Prednisone)	o
o Cholesterol medication	o
o Decongestants	o
o Diuretics (water pills)	o
o Hormones (birth control, estrogen)	o
o Inhalants	o
o Insulin	o
o Heart medication / nitroglycerine	o
o Muscle relaxants	o
o Pain medication (Aspirin, Advil, Tylenol)	o
o Sleeping pills	o
o Thyroid medication	o
o Tranquilizers	o
o Vitamins	o
o Others	o

LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING. IF NECESSARY, ATTACH A LIST TO THIS FORM.

1)_____ 5)_____ 9)_____ 13)_____
2)_____ 6)_____ 10)_____ 14)_____
3)_____ 7)_____ 11)_____ 15)_____
4)_____ 8)_____ 12)_____ 16)_____

Are you *ALLERGIC* to any of the following (get hives, a rash, have trouble breathing, etc.):

0 Antibiotics (penicillin, tetracycline)
0 Local dental anesthetics (novocain)
0 Codeine
0 Aspirin
0 Barbiturates or sedatives
0 Tranquilizers
0 Others

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	0	0
Do you have any disease, condition or medical problem not listed you feel we should know about?	0	0

Please answer the following:

1) Are you happy with your smile? ____
2) Are you happy with the color of your teeth? ____

3) On a scale from 1 – 10, how much do you value your oral health? ____
4) On a scale from 1 – 10, how much do you value your overall health? ____

5) Do you or anyone in your family snore? ____
6) Have you ever been told you stop breathing or gasp in your sleep? ____

7) Have you had Botox® and/or Dermal Filler procedures in the past? ____

8) Are your teeth straight? ____
9) Have you had braces in the past? ____
10) Are you interested in straightening your teeth without traditional metal braces? ____

P a t i e n t S i g n a t u r e

X Date:

(Office Use Only)

D o c t o r S i g n a t u r e

X Date:

NOTES:

BP _____
RESP _____
PULSE _____

HEALTH HISTORY

Over Please →

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dental care
A Beautiful Smile is Always in Season

CANCELLATION POLICY

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. Please keep in mind, **a broken appointment is a loss to three people: you – the patient, another patient who could have benefited from your time slot, and the doctor who was fully staffed and prepared for the appointment.**

Therefore, we ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a $125 fee may be assessed to your account per hour of reserved treatment time. Please note, we reserve the right to not schedule further appointments in the event a broken appointment ("no show") trend begins.

_____ _____

Signature Date

ACKNOWLEDGEMENT, RELEASE AND FINANCIAL POLICY

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit insurance claims and reports as a courtesy to assist you in obtaining maximum benefits available. Please note, the dentist's treatment recommendations are not affected by the presence or absence of insurance. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company, therefore we do not confirm insurance eligibility or predetermine recommended treatment.

Financial Policy (Collections)

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. The following is a statement of our financial policy which we require that you read, agree to, and sign prior to any treatment.

Pay by cash, check or credit card (Visa®, MasterCard® and Discover®)

All payments, insurance co-payments and deductibles are due in full at time of service. Fees not paid at time of service may result in a $20.00 administrative surcharge. In the event a balance becomes more than 60 days overdue, billing may be turned over to a collections agency. A collection fee of 33% will be added to your balance. The responsible party listed below agrees to pay interest, collection costs and other legal expenses related to the collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term of condition.

_____ _____

Signature Date

Over Please →

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how Healthcare information about you may be used by *Seasons Dental Care*. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

"I acknowledge that I have received the full Privacy Notice."

_____	_____	_____
Name (print)	Signature	Date
_____	_____	_____
Witness	Signature	Date

seasons dental care
A Beautiful Smile is Always in Season

John K. Pontikes, D.M.D.
General, Cosmetic and Implant Dentistry

GENERAL RESTORATIVE INFORMED CONSENT and POLICY ON PROVIDING PUNCTUAL CARE

Facts You Need To Know

"Quality is never an accident, it is always the result of high intention, sincere effort, intelligent direction, and skillful execution; it represents the wise choice of many alternatives."

TOOTH DECAY: Some individuals are more prone to tooth decay than others. With a highly refined carbohydrate diet or inadequate home care, tooth decay may occur on areas of the tooth or root not covered by a dental crown. If the decay is discovered at an early stage, it can often be filled without remaking the crown or fixed bridge. Long delays in treatment, a loose provisional, or permanent crowns and bridges can result in additional decay, the "death" of a tooth nerve, which would require a root canal or even the loss of a tooth and/or teeth.

POTENTIAL PROBLEMS WITH FIXED PROSTHODONTICS: Crowns and fixed bridges are used to treat problems of decay, severely worn or fractured teeth, malocclusion, and to protect teeth that have had root canal treatment. However, because dental restorations are replacements for natural teeth, potential problems do exist. Below, are brief descriptions of the most commonly encountered problems. Questions about your specific case are encouraged.

PROVISIONAL (Temporary) RESTORATIONS: Provisional crowns and fixed bridges are used to protect the teeth and to provide a satisfactory appearance while the new permanent crown(s) and fixed bridge(s) are being fabricated. A provisional restoration is usually made of acrylic resin, which is not as strong as the final porcelain/metal restoration. A provisional is attached to the teeth with temporary cement; therefore, it is important to minimize the chewing pressure on a provisional restoration since it can fracture and/or become dislodged. If this does occur, call our office as soon as possible for repair or recementation. Waiting more than a couple days can create unnecessary problems, and may delay your treatment.

PORCELAIN FRACTURES: Porcelain is the most suitable material for the esthetic replacement of tooth enamel. Because porcelain is a "glass-like" substance, it can break. However, the strength of dental porcelain is similar to dental enamel, and the force necessary to fracture dental porcelain would usually fracture natural tooth enamel. Small porcelain fractures can possibly be repaired; larger fractures often require a new crown or fixed bridge.

LOOSE CROWN or LOOSE FIXED BRIDGE: A dental crown or fixed bridge may separate from the tooth if the cement is lost or if the tooth fractures beneath it. Sometimes loose crowns and fixed bridges can be recemented, but teeth that have extensive recurrent decay or fractures will usually require a new crown or new fixed bridge.

EXCESSIVE WEAR: Sometimes crowns and fixed bridges are used to restore badly worn teeth. If the natural teeth were worn from clenching and grinding the teeth (bruxism), the new crowns and fixed bridges may be subjected to the same wear. In general, dental porcelain and metal alloys wear at a slower rate than tooth enamel. However, excessive wear of the crowns or fixed bridges may necessitate an acrylic resin mouth guard (also called a protective occlusal splint or night guard.)

ESTHETIC CONSIDERATIONS: It is our intent to use our technical and artistic capabilities to achieve your esthetic expectations and to incorporate these factors into your final dental restorations. You are asked to communicate your desires, and our best efforts will be applied toward incorporating your wishes in harmony with the functional and physiological requirements of the restorations. After your approval, the restorations will be finalized. Please note that only very MINOR changes to the *shape* of the restorations can be made after finalization. NO changes to color can be made after finalization.

Some changes in appearance may be beyond the capabilities of restorative and prosthetic dentistry. A consultation with other dental or medical specialists may be suggested.

STAINS and COLOR CHANGES: All dental restorative materials can stain. The amount of stain generally depends on oral hygiene as well as the consumption of coffee, tea, tobacco, and some types of foods or medicines. Dental porcelain usually stains less than natural tooth enamel, and the stain can be removed at dental hygiene cleaning appointments. Natural teeth tend to darken with time moreso than porcelain crowns. At the time a new dental porcelain crown or fixed bridge is placed, it may be an excellent color match with the adjacent natural teeth. Over time, however, this may change and bleaching or other appropriate treatment may be suggested.

Over Please →

BLEACHING: Bleaching provides a conservative method of lightening teeth. There is no way to predict to what extent a tooth will lighten. In a few instances, teeth may be resistant to the bleaching process, and other treatment alternatives may be advised. Infrequently, side effects such as tooth hypersensitivity and gum tissue irritation may be experienced. If these symptoms occur, consult Dr. Pontikes.

IMPLANTS: Longevity depends on many factors – the patient's health, the use of tobacco, alcohol, drugs, sugar, oral hygiene, the amount of quality bone, surgical compromises, the degree of biting force, etc. As with any restorative procedure, the potential exists for the fracture of an implant component, implant crown, or loss of the implant from the bone.

ADDITIONAL INFORMATION: Sometimes when teeth are prepared for crowns, due to the extent of wear, deep decay, large fillings or old crowns, the additional "trauma" to an already compromised tooth can possibly cause the nerve of the tooth to die. This usually requires root canal therapy. Depending on the complexity of the tooth roots, you may be referred to an endodontist (a specialist who does root canal treatment). It does not normally require changes in your treatment plan.

MAINTENANCE: Even the most beautiful restorations can be compromised by gum problems, recurring cavities and poor oral hygiene habits. Part of our commitment to you is to provide you with the proper information to keep your gums and teeth (natural or restored) in good health. Professional cleaning by a dentist or dental hygienist at recommended intervals keeps your mouth healthy and can intercept potential problems early enough to avoid additional restorative work or unnecessary discomfort. It is also important to maintain a professional cleaning schedule throughout the course of your dental treatment.

INFORMED CONSENT

Patient's Name _____ **Date** _____

I certify that I have read and understand all of this INFORMED CONSENT which outlines the general treatment considerations as well as the potential problems and complications of dental treatment. I understand that potential complications and problems may include, but are not limited, to those described in this document. I have been given the opportunity to ask questions about the proposed treatment and the risks, as well as the potential consequences should I elect to postpone or refuse treatment. I understand that during and following treatment, conditions may arise that warrant additional or alternative treatment. I further understand that no guarantees can be made for a successful result.

Recognizing the potential problems and risks of treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. In addition, I grant permission for photographs taken by Dr. Pontikes, or photographs released from other healthcare practitioners, of the procedures to be used for educational and teaching purposes only.

Signed _____ Date _____
(Please initial each page to indicate that you have read and understood the content.)

Witness _____ Date _____

POLICY ON PROVIDING PUNCTUAL CARE

Seasons Dental Care's priority and obligation is to provide the highest level of care to all its patients in a timely manner.

We understand that many are pressed for time, however, dentistry is an art & science and the integrity of the profession & well-being of our patients will never be compromised in the pursuit of being punctual when, at times due to circumstances not under our control, it is not possible.

Please know, we value your patronage & time and always do our best to remain on time.

Thank you for your understanding,
The Seasons Dental Care® Team

Signed _____ Date _____