SARATOGA HEALTHY SMILES
IRINA VAYNSHTEYN DDS

PATIENT INFORMATION

Last Name: _____ First Name: _____MI: _____ Date: _____

Address_____Apt #_____City_____State____Zip_____

Home Phone (_____) _____Work Phone (_____) _____Cell (_____) _____

SS# _____DOB: _____Height: _____Weight: _____ Gender: _M_F

Email_____ How may we contact you for upcoming appointments? Phone/Text/Email

Emergency contact: _____Relationship: _____ Home Phone (_____) _____Work Phone (____) _____

DENTAL INSURANCE POLICY HOLDER INFORMATION

Primary:

Insurance Company Name_____ Insurance Phone (____) _____

Insured Name_____ Insured DOB_____

Insured Employer_____ Patient's relationship to insured: _self _spouse _child _other

Insured ID#_____Group#_____

Secondary:

Insurance Company Name_____ Insurance Phone (____) _____

Insured Name_____ Insured DOB_____

Insured Employer_____ Patient's relationship to insured: __self __spouse __child __other

Insured ID#_____Group#_____

I hereby authorize assignment of my insurance rights and benefits directly to Saratoga Healthy Smiles for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

_____ _____

(Insured's signature) (Date)

MEDICAL PLAN POLICY HOLDER INFORMATION

Plan Name_____ Insurance Phone (___) _____

Name of insured _____Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship _____ Policy _____

I hereby authorize assignment of my insurance rights and benefits directly to Saratoga Healthy Smiles for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

_____ _____

(Insured's signature) (Date)

CONSENT TO PROCEED/ POLICIES

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Check, Visa, MasterCard, American Express, Care Credit, and Cash

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service or time of scheduling your appointment. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 2 business days to reschedule an appointment. With less than 48-hour notice, a fee of $ 50 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $25 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (Initial)

I have read the above and agree to the financial and scheduling terms. _____ (Initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice._____ (Initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (Initial)

Waiver or breach of contract: You agree that a waiver or breach of any term or condition of this agreement will not automatically void any other term or condition of this contract and you agree to pay any costs and reasonable attorney fees involved with any lawsuit involved with this agreement.

_____ I consent to the use of my photographs for marketing advertisement, articles, lectures, and laboratory use.

_____ I **DO NOT** consent to the use of my photographs.

I have read the above conditions for treatment and payment and agree to their content, and understand that any use of the word "you" in the above refers to me, the undersigned.

Permission to Contact: I give you my permission for you or your assignee to contact me by telephone or other means.

Patient name: _____
Signature: _____Date:_____

(Patient, legal guardian and authorized agent of patient)

Witness: _____Date:_____

DENTAL HEALTH HISTORY

Patient Name _____

The information you provide is important to your health. If you have any questions, do not hesitate to ask.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure? ……..	☐	☐	☐
Does food or floss catch between your teeth? ……..	☐	☐	☐
Have you had any periodontal (gum) treatments? ……..	☐	☐	☐
Have you ever had orthodontic (braces) treatment? ……	☐	☐	☐
Does the amount of saliva in your mouth seem too little? ……	☐	☐	☐
Does your mouth feel dry when eating a meal? ……	☐	☐	☐
Do you have difficulty swallowing any food? ……	☐	☐	☐
Do you sip liquids to aid in swallowing dry foods? ……	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

	Yes	No	DK
Are you currently experiencing bad breath? …….	☐	☐	☐
Do you have earaches or neck pains? ...	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw? …….	☐	☐	☐
Do you brux or grind your teeth? …	☐	☐	☐
Do you have sores or ulcers in your mouth? …….	☐	☐	☐
Do you wear dentures or partials? ...	☐	☐	☐
Have you ever had a serious injury to your head or mouth? ……	☐	☐	☐
Are your teeth turning yellow or losing brightness? ……...	☐	☐	☐
Have you had any problems associated with previous dental treatment? …..	☐	☐	☐
Does dental treatment make you nervous? ……..	☐	☐	☐

If yes, what can we do to make your dental visit more comfortable? _____

Are you currently experiencing dental pain or discomfort? _____

What is the reason for your dental visit today? _____

Date of your last dental exam: _____ What was done at this time? _____

Date of your last dental x-rays: _____

How do you feel about your smile? _____

What about your smile that you would like to change?

- ☐ Make teeth whiter
- ☐ Close spaces
- ☐ Replace stained front fillings
- ☐ Change silver fillings to white ones
- ☐ Repair chipped teeth
- ☐ Other: _____

Who should we thank for referring you to our office?

- ☐ postcard by mail
- ☐ friend/relative _____
- ☐ referral card
- ☐ insurance company
- ☐ internet
- ☐ patient referral _____
- ☐ other _____

MEDICAL HISTORY

Patient Name: _____

Are you under the care of a physician? YES NO

Physician Name: _____ Physician's Number: _____

Address/City/State/Zip: _____

Has there been any change in your general health within the past year? _____

If YES, what condition is being treated? _____

Date of last physical: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? _____

If YES, what was the illness or problem? _____

Please list all prescription medication you are currently taking or have recently taken, including vitamins, natural or herbal preparations and/or diet supplements:

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Congestive heart failure ……	☐	☐	☐	Artificial (prosthetic) heart valve ……	☐	☐	☐
Damaged heart valves ……...	☐	☐	☐	Previous infective endocarditis ……...	☐	☐	☐
Heart attack ……...	☐	☐	☐	Damaged valves in transplanted heart ...	☐	☐	☐
Heart murmur ……	☐	☐	☐	Congenital heart disease (CHD) ……..	☐	☐	☐
Low blood pressure ……...	☐	☐	☐	Unrepaired, cyanotic CHD ……..	☐	☐	☐
High blood pressure ……..	☐	☐	☐	Repaired (completely) in last 6 months ..	☐	☐	☐
Other congenital heart defects ……..	☐	☐	☐	Repaired CHD with residual defects …..	☐	☐	☐
Mitral valve prolapse ……	☐	☐	☐	Have you ever taken Fen-Phen or Redux?			
Pacemaker …….	☐	☐	☐	Cardiovascular disease ……	☐	☐	☐
Rheumatic fever ……	☐	☐	☐	Angina …….	☐	☐	☐
Rheumatic heart disease ……	☐	☐	☐	Shortness of breath ……..	☐	☐	☐
G.E. Reflux/persistent heartburn ……...	☐	☐	☐	Arteriosclerosis ……...	☐	☐	☐
Ulcers ……	☐	☐	☐	Abnormal bleeding ……..	☐	☐	☐
Thyroid problems ……..	☐	☐	☐	Anemia ……	☐	☐	☐
Herpes ……...	☐	☐	☐	Easy bruising ……...	☐	☐	☐
Stroke ……	☐	☐	☐	Frequent nose bleeds ……...	☐	☐	☐
Glaucoma ……..	☐	☐	☐				

	Yes	No	DK
Gastrointestinal disease	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify _____			
Recurrent infections	☐	☐	☐
Type of infection	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Blood transfusion	☐	☐	☐
When? _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Cancer/Tumor/Chemotherapy/Radiation			
Tuberculosis	☐	☐	☐
Sinus trouble	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐

	Yes	No	DK
Have you had an orthopedic total joint (hip, knee, elbow, and finger) replacement? Date: _____ Any complications?_____	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel® for osteoporosis or Paget's disease?.....	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... Date treatment began: _____	☐	☐	☐

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? ..... If so, how interested are you in stopping? (Circle one) VERY/SOMEWHAT/NOT INTERESTED	☐	☐	☐
Do you drink alcoholic beverages? If yes, how much alcohol did you drink if within the last 24 hours? _____ If yes, how much do you typically drink in a week? _____	☐	☐	☐

WOMEN ONLY: Are you:

	Yes	No	DK
Pregnant? Number of weeks: _____	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

ALLERGIES: Are you allergic to or have you had a reaction to:

	Yes	No	DK		Yes	No	DK
Local anesthetics	☐	☐	☐	Metals	☐	☐	☐
Aspirin	☐	☐	☐	Latex (rubber)	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐	Iodine	☐	☐	☐
Barbiturates, sedatives, or	☐	☐	☐	Hay fever/	☐	☐	☐
Sulfa drugs	☐	☐	☐	Animals	☐	☐	☐
Codeine or other narcotics	☐	☐	☐	Food	☐	☐	☐
Other_____	☐	☐	☐				