Welcome to Our Practice...

AESTHETIC FAMILY DENTISTRY, P.A.

40 Years of Advanced Programs in Personal Image Enhancement

- **Derek Fine, DMD**
- **Jenni Kwiatkowski, DDS**
- **Alan B. Steiner, DMD**

35 West Main Street | Suite 208 | Denville, NJ 07834

T 973 627-3617 F 973 627-5069

info@aestheticfamilydentist.com www.aestheticfamilydentistry.com

Thank you for choosing our office for your dental needs.

Please take a few minutes to complete this confidential questionnaire so we may better serve you.

Today's Date ______________________

Patient Name ______________________

Patient Address ______________________

City ______________________ State ____________ Zip ____________

Patient SS# ______________________ Date of Birth ______________________ Sex M ____ F ____

Home Phone (   ) ______________________ Business Phone (   ) ______________________ Ext. Number ____________

Cell Number (   ) ______________________

Can we call you at work? ____________ Yes ____________ No E-mail Address ______________________

In Case of Emergency, contact ______________________

Relationship to patient ______________________ Phone (   ) ______________________

Please check one: ______ Single ______ Married ______ Partner ______ Divorced ______ Widow ______ Widower

Patient/Parent employed by ______________________

Occupation ______________________ How long employed? ____________

Primary Dental Insurance ______________________

Secondary Dental Insurance ______________________

Please present insurance card to receptionist.

Your Smile

Is there anything about your smile you would like to change? ______________________

On a scale of 0-10 with 10 being the highest:

How important is your dental health to you? ______________________

Where would you rate your current dental health? ______________________

Do you have a bad taste in your mouth or bad breath? ______________________

Do you have any type of dental appliance? ______________________

Your Visit Today

What is the most important thing to you about your dental visit today? ______________________

How did you learn of our office? ______________________

What prompted you to seek dental care at this time? ______________________

Are you having pain, discomfort or sensitivity at this time? ____________ If so, please explain ______________________

____

Health History

It is IMPORTANT that we know about your Medical/Dental History. These facts have a direct bearing on your dental health.

When was your last dental check-up? ______

Name of your last dentist ______ Why did you leave? ______

What did you like most about your previous dentist? ______

Do you feel very nervous about dental treatment? ______

Do you smoke? ______ If yes, how much? ______

Have you been a patient in the hospital during the past two years? ______ If yes, for what? ______

Have you been under the care of a medical doctor during the past year? ______ If yes, for what? ______

For Women only Are you pregnant? ______ Yes ______ No If yes, what month? ______ Are you taking birth control pills? ______ Yes ______ No

Physician's Name ______ Cardiologist's Name ______

Address ______ Address ______

Phone ______ Phone ______

Are you taking any medication, drugs, supplements or vitamins at this time? ______ If yes, please list ______

Rx 1. ______ What for? ______

Rx 2. ______ What for? ______

Rx 3. ______ What for? ______

Rx 4. ______ What for? ______

Rx 5. ______ What for? ______

Rx 6. ______ What for? ______

Rx 7. ______ What for? ______

Rx 8. ______ What for? ______

Rx 9. ______ What for? ______

Rx 10. ______ What for? ______

Do you need to be premedicated prior to dental appointments? ______ Rx ______

If yes, why? ______ ______

Have you taken any medications for osteoporosis or bone density? ______

Do you, or have you ever had any of the following symptoms?

______ Headaches
______ Pain in your Jaw
______ Noises in your Jaw (opening)
______ Noises In Your Jaw (closing)
______ Limited Opening
______ Jaw Locking
______ Earache
______ Ear Congestion
______ Vertigo (dizziness)
______ Tinnitis (ringing in ears)
______ Dysphagia (difficulty swallowing)
______ Loose Teeth
______ Clenching

______ Facial Pain (non specific)
______ Tender Sensitive Teeth (biting)
______ Diffculty Chewing
______ Postural Problems
______ Paresthesia of Fingertips (tingling)
______ Thermal (hot/cold) Sensitivity
______ Trigeminal Neuralgia
______ Bells Palsy
______ Insomnia
______ Snoring or sleep issues
______ Sleep Apnea
______ Do you suffer from neck, shoulder or back pain?
______ Grinding

Are you allergic or have you reacted adversely to any of the following medications? If so, please circle.

Aspirin	Amoxicilin	Tetracycline	Xylocaine	Local Anesthetic	Nut Allergy
Nitrous Oxide	Sulfa Drugs	Penicillin	Sleeping Pills	Latex	
Codeine	Erythromycin	Valium	Cortisone Medicine	Other Antibiotics ________	

Please list any other medications or substances you are aware of being allergic to: ____________________

Circle any of the following which you have had or have at present:

Mitral Valve Prolapse	Artificial Joints (Hip, Knee)	HPV	Sinus Trouble	Hepatitis Type A (infectious)
Heart Disease of Attack	Allergies or Hives	Tested HIV Positive	Liver Disease	Hepatitis Type B (serum) or other
Heart Murmur: Functional/Non-Functional		Anemia	Diabetes	Hepatitis Type C
Stroke	Kidney Trouble	Radiation Therapy	Thyroid Disease	Drug or Alcohol Addiction
Angina Pectoris	High Blood Pressure	Ulcers	Chemotherapy	Blood Transfusion (Date of ________)
Fever Blisters	Rheumatic Fever	Cosmetic Surgery	Arthritis	Cancer or Leukemia (Date ________)
Epilepsy/Seizures	Congenital Heart Lesions	Acid Reflux / GERD	Emphysema	Cold Sores
Fainting/Dizzy Spells	Scarlet Fever	Chronic Cough	Rheumatism	Glaucoma
Nervousness	Artificial Heart Valve	Tuberculosis (TB)	Hemophilia	Bruise Easily
Psychiatric Treatment	Heart Pacemaker	Heart Surgery	Asthma	Cosmetic Surgery

Do you have a family history of any of the following: Please circle

Heart Disease   High Blood Pressure   Stroke   Diabetes   Periodontal Disease

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE.

CONSENT: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ____________________ and further authorize and consent that Doctor choose and employ such assistance as deemed fit.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due payable at the time services are rendered unless financial arrangements have been made.

I further understand that a 1 1/2% finance charge (18% annually) may be added to any balance over 90 days. In the event of default, I (We) promise to pay legal interest on the indebtedness together and with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient name ____________________ Date ____________ Witness ____________________

Relationship to Patient ____________________

Signature ____________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my potential health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment among healthcare providers involved in that treatment,directly or indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations.

I have had the opportunity to read the complete Notice of Privacy Practices. I understand that changes to notice of Privacy Practices may occur and that I may contact this organization to obtain a current copy.

I understand that I may request in writing that you restrict how information is disclosed.

Patient name ____________________

Relationship to patient ____________________

Signature ____________________ Date ____________

FOR OFFICE USE ONLY

Waterpik

Whitening

Perio Protect

Oral DNA

Huggins

No FL2

NO mint

Tooth & Gum Tonic

Nightguard

Prevident

Vitamins

Holistic

DISC

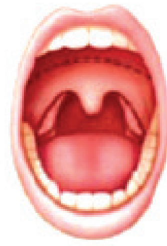
Scan

Implant ______________________

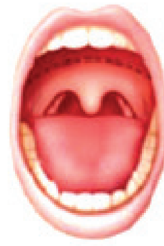
Periodontist ______________________

Orthodontist ______________________

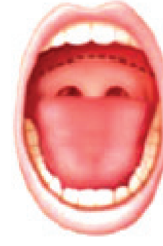
Sleep Study ______________________



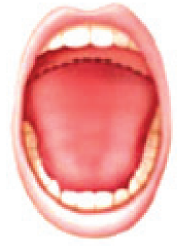
I
Entire uvula and tonsils are visible



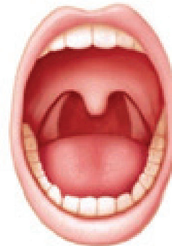
II
Entire uvula is visible, but tonsils are not visible



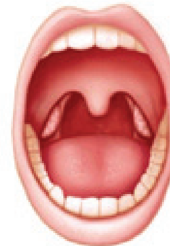
III
Soft palate is visible, but uvula is not visible



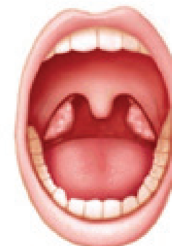
IV
Only hard palate is visible



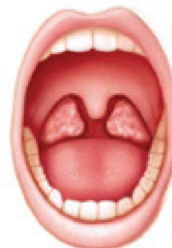
0
Surgically removed tonsils



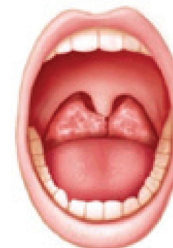
1
Tonsils hidden within tonsil pillars



2
Tonsils extending to the pillars



3
Tonsils are beyond the pillars



4
Tonsils extend to midline

Last Models ______________________

____

Last FMX ______________________

____

Shimbashi ______________________

Crowding ______________________

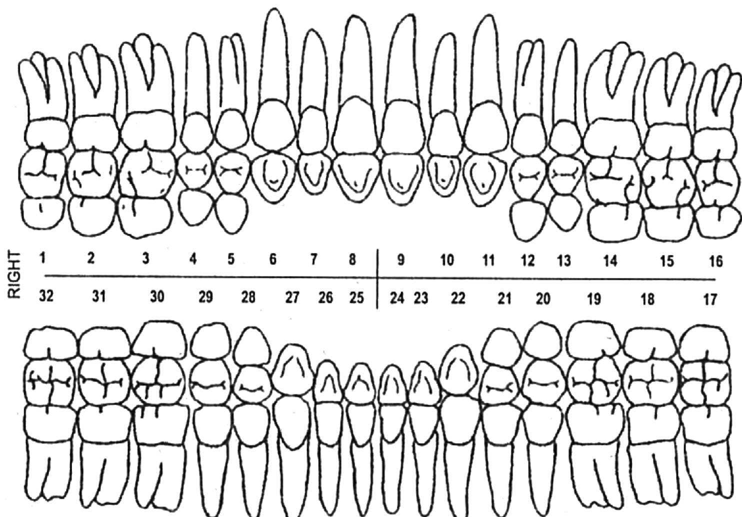
Wear Facets ______________________

Cervical Erosion ______________________

Cross-Bite ______________________

Date ______________________

Pre-existing Findings



REMARKS...

____

____

____

____

____

____

____

Photography Release

AESTHETIC FAMILY DENTISTRY, P.A.
40 Years of Advanced Programs in Personal Image Enhancement

- **Derek Fine, DMD**
- **Jenni Kwiatkowski, DDS**
- **Alan B. Steiner, DMD**

35 West Main Street | Suite 208 | Denville, NJ 07834
T 973 627-3617 F 973 627-5069
info@aestheticfamilydentist.com www.aestheticfamilydentistry.com

Thank you for choosing our office for your dental needs.
Please take a few minutes to complete our photography release form

I,____, hereby consent and authorize Aesthetic Family Dentistry to take photographs and/or videos of my face, jaws and teeth.

I understand that the photographs and/or videos will be used as a record of my care, and may be used with or without my given name or with a fictitious name for educational purposes in lectures, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose.

I release and forever discharge them from any claim, demands or liability on account of such use or for the quality of the reproduction of the image.

____________________ ____________________
SIGNATURE DATE

____________________ ____________________
WITNESS DATE

Minors only: If the signature above is by a person under age 18, parent or guardian should sign here:

I____, parent or guardian hereby consent to the release as stated above.