Pure Smiles

8185 Lee Vista Blvd, Suite 200 • Orlando, FL 32829 • Tel: (407)881-1751 • email: dr.rivera@puresmilesfl.com

WELCOME TO OUR PRACTICE

Today's Date: _____ Chart#: _____

(For office use only)

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Date of Birth:: _____ SS#: _____ Gender: _____ Mr/Ms/Mrs/Etc _____

Name of Parent / Guardian / Responsible Party _____ ○ Married ○ Single ○ Child ○ Other

Email Address: _____ Preferred phone _____ ○ Call ○ Text

Phone: _____ (Mobile) _____ (Home) _____ (Work)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Emergency Contact: _____ (Name) _____ (Phone) _____ (Relation)

Who may we thank for referring you to our practice? _____

Primary Dental Insurance: Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Name of Policy holder: _____ (Last) _____ (First) ____ (MI)

Policy holder D.O.B: _____ SS#: _____ ID#: _____

Group#: _____ Insurance Plan Name: _____

Insurance / Provider Serv phone: _____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

_____ (Signature of Responsible Party) _____ (Name) _____ (Date)

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MEDICAL HISTORY

Indicated which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Diabetes	☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Frequent Headaches	☐ Glaucoma	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Pacemaker
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Sleep Apnea	☐ Stomach Problems	☐ Stroke	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	☐ Other _____	

☐ Ever been hospitalized (illness or injury)

☐ Presently being treated for any other illnesses _____

☐ Taking Blood thinners _____

☐ Tobacco / smoker ☐ Current ☐ History

☐ Taking medication for weight control (is fen-phen)

☐ Taking dietary supplements

☐ Recreational Drugs _____

☐ History of Addiction _____

☐ Taking birth control pills

☐ Currently Pregnant _____ weeks ☐ Nursing

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

List all medications, supplements, and/or vitamins currently taking

_____

_____

Do you take antibiotic premedication for your dental visits? ☐ Yes (please explain) _____ ☐ No

Are you allergic to ANYTHING? ☐ Yes (please explain) _____ ☐ No

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician, specialty & phone number _____

_____

☐ **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Print Name	Signature	Date
_____	_____	_____

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DENTAL INFORMATION

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last dental exam: _____ **last dental x-rays:** _____ **last dental cleaning** _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern? _____

Are you fearful of dental treatment? How fearful, on a scale 1 (least) to 10 (most): _____

Personal Dental History, Check all that apply:

☐ Unfavorable dental experience ☐ Complications from past dental treatment ☐ Had trouble getting numb

☐ Had any reactions to local anesthetic ☐ Had/Have braces, orthodontic treatment ☐ Had any teeth removed ☐ Had your bite adjusted

Smile characteristics, check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change? _____

☐ Have you ever whitened (bleached) your teeth?

☐ Do you feel uncomfortable or self- conscious about the appearance of your teeth? _____

☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ Have your teeth changed in the last 5 years, become shorter, thinner, or worn ☐ Problems with your jaw joint

☐ Noticed your teeth crowding or developing spaces ☐ Any problems chewing

☐ You clench your teeth in the daytime or make them sore ☐ You wear or have worn a bite appliance

☐ You have problem with sleep or wake up with awareness of your teeth

☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits _____

Tooth structure, Check all that apply:

☐ Cavities within the past 3 years ☐ Food gets caught between any teeth ☐ Teeth sensitive to hot, cold, biting, sweets

☐ Dry mouth ☐ Have any teeth that are causing pain, have holes, notches, are chipped? _____

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing ☐ Experienced gum recession ☐ Unpleasant taste or odor in your mouth

☐ Treated for gum disease or were told you have bone-loss around your teeth ☐ History of periodontal disease in your family

☐ Had any teeth become loose on their own (without injury) ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation: _____

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DENTAL PRACTICE FINANCIAL POLICY

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

☐ **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.**

Notice of Privacy Practices Acknowledgement.

The privacy of your health information is important to us. Our notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

☐ **By checking this box, I acknowledge that I have received a copy of the dental practice's Notice of Privacy Parties.**

Name _____ **Relationship to patient:** _____

Signature of patient, parent / guardian / responsible party: _____ **Date:** _____

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GENERAL DENTISTRY INFORMED CONSENT

All patients MUST complete 1 thru 4 below, and 5 thru 13 as needed. **Chart#_____**

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased with the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic. medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance o effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential or accompanying risks, side effects. and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking.

The written informed consent. in the case of a minor, shall include, but not be limited to, the following information: in the administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment and consult with your dentist or pediatrician as needed.

(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking. locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials_____)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials_____)

6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal crown. or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials_____)

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain. swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

8. CROWNS, BRIDGES. VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow or decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials_____)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials_____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant, and crown may not be a covered benefit under my insurance policy.

(Initials_____)

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9. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials_____)

10. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials_____)

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/ or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature. it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials_____)

12. IMPLANTS

I understand that no dentistry is permanent, and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials_____)

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials_____)

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials_____)

15. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand tha1 each Dentist Is an individua l practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient / Guardian Signature _____ **Date:** _____

Doctor: _____ **Date:** _____