General
Cosmetic Dentistry
at
Dr. Steven Blechman's
Dental ARTS of Rockland
Ph: 845-359-0407
Fax: 845-359-0429
523 Route 303
Orangeburg, NY 10962
dentalartsofrockland.com

Dear:

We would like to welcome you to our ***Dental Spa!*** We are looking forward to caring for you and your dental health. Our goal is to provide you with the ***highest quality cosmetic, general, and preventive dentistry in a comfortable and relaxing environment***. We promise you our ***professionalism, quality, skill, and expert ability. Our dedication*** is to your oral health care and providing you with ***optimal dental treatment and recommendations.***

To create a more pleasant and memorable dental experience we are pleased to offer you the following ***Complimentary Amenities from our Dental Spa:***

- Gourmet Coffee Bar
- Gourmet Herbal Teas
- Pre-appointment Single Use Toothbrush
- Personal TV & Music (Direct TV) with Headphones
- Cozy Dental Fleece Blankets
- Heated Neck Wraps
- Cool Eye Compresses
- Therapeutic Hand Paraffin Treatment
- Heated Towelettes
- Courtesy Patient Telephone

Our Dental Spa Amenities are designed to help you ***relax*** before, during, and after your visit with us.

In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that at any time you have a question about any treatment (proposed or performed), fee for service, or about our "Dental Team," you will discuss it with us promptly and openly. We look forward to a continued friendship and professional relationship.

Sincerely,

Dr. Steven Blechman and Your Dental Team

Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ (Last Name / First Name / Middle Initial) Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides.

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____ Date of last visit _____

Have you had any serious illnesses or operations? ❑ Y ❑ N If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check Y for yes or N for no if you have or have not had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic fever
❑ Y ❑ N Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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 _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Smile Evaluation

*Name:*_____ *Date:*_____

1. What makes you least comfortable in a dental practice?
Explain:_____

2. What makes you feel most comfortable in a dental practice? _____
What can we do to make your experience more comfortable?
Explain:_____

3. Do you like the way your teeth look? Yes No
Explain:_____

4. Are you happy with the color of your teeth? Yes No
Explain:_____

5. Would you like your teeth to be whiter? Yes No
Explain:_____

6. Would you like your teeth to be straighter? Yes No
Explain:_____

7. Do you have space between your teeth that you would like to be closed? Yes No
Explain:_____

8. Would you like your teeth to be longer? Yes No
If so, Upper_____ Lower_____ Both_____?

9. Do you like the shape of your teeth? Yes No
Explain:_____

10. Do you have missing teeth that you would like to replace? Yes No
Explain:_____

11. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes No
Explain:_____

12. If you could change anything about your smile, what would you change? _____

_____

13. Would there be any reason, not to go ahead with any needed dental treatment?