AJ Dental, LLC

Cosmetic & Implant Dentistry

Date: _____

Patient's Name: _____ Social Security#: _____

How do you wish to be addressed? _____ Date of Birth: _____ Age: _____

☐ Male ☐ Female ☐ Transgender ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ No answer

Street Address: _____ City: _____ State: _____ Zip code: _____

Home Phone#: _____ Cell Phone#: _____ E-mail: _____

If Minor – Parent's/Guardian's Name: _____ ☐ Male ☐ Female ☐ Transgender

Street Address: _____ City: _____ State: _____ Zip code: _____

How may we contact you? ☐ Cell phone (Call/Text message) ☐ E-mail ☐ Home Phone

Languages spoken: _____ . _____ . _____

Preferred language: _____

How did you hear about us? _____

Whom may we thank for this referral? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone#: _____

FINANCIAL AGREEMENT AND INSURANCE COVERAGE CONSENT

I certify that I, and/or my dependent(s), have insurance coverage with the Insurance Company provided and assign directly to AJ Dental, LLC all insurance benefits, if any, for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I authorize the use of my signature on all insurance submissions.

AJ Dental, LLC may use my healthcare information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This Consent will stay in effect as long as I am a patient with AJ Dental, LLC.

RESCHEDULE / CANCELLATION POLICY

Our office strives to provide the best care and service to our patients. In order to provide care at a time that is convenient our patients, we rely on and appreciate your commitment to your appointments. We also understand that there are times where patients may not be available as scheduled. As a courtesy, we ask that you notify our office **24 hours in advance** to cancel and/or reschedule your appointment.

Please be aware that failure to provide notice within the **24 hours** allowed timeframe will result in a **fee of $50**.
A **$50 administrative fee** will be retained for any pre-paid treatment that you choose to discontinue.

X___ _____ _____

Signature of Patient or Parent/Guardian Date

155 Main St. Suite 400 | Danbury, CT 06810-7844
Office: (203) 587-7999 | Fax: (203) 826-9538
www.ajdentalct.com | ajdental@ajdentalct.com

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HEALTH HISTORY

Please circle "YES or NO" to indicate if you have, or have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Shortness of breath	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis Type _____	Yes	No	Special Diet	Yes	No
Bleeding Abnormally	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood Disease _____	Yes	No	High Blood Pressure	Yes	No	Swollen Feet/Ankles	Yes	No
Cancer _____	Yes	No	Jaundice	Yes	No	Swollen Neck/Glands	Yes	No
Drug Dependency	Yes	No	Jaw Pain	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesion	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors	Yes	No
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Cough - Persistent, Bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes _____	Yes	No	Psychiatric Care	Yes	No	Weight Loss, severe	Yes	No
Emphysema	Yes	No	Radiation Treatment	Yes	No	ADD/ADHD	Yes	No

Comments: _____

Have you ever had any serious illness not listed above? Yes No _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No _____

Have you ever taken Fosamax, Boniva, Actoner or any other medications containing bisphosphonates? Yes No _____

Do you wear contact lenses?	Yes	No	
Taking Birth Control?	Yes	No	
Are you pregnant?	Yes	No	Due Date: _____
Are you nursing?	Yes	No	
Have you had any major surgery?	Yes	No	_____
Do you use tobacco?	Yes	No	Frequency: _____

Allergies *Are you allergic to:*

Aspirin	*No Known Allergies: ____*
Barbiturates (Sedatives)	Latex
Codeine	Iodine
Penicillin	Local Anesthetics
Other: _____	

Medications *List any Medications, Vitamins, or Supplements you are taking:*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any serious illness that run in your family? Yes No _____

_____

_____

I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor and other office personnel at the next appointment.

X___ _____ _____

Signature of Patient or Parent/Guardian | Doctor's Signature | Date

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DENTAL HISTORY

Please circle "YES or NO or DK " to answer the following questions: **DK = Don't Know**

Do your gums bleed when you brush or floss?	Yes	No	DK	Do you have any clicking, popping or discomfort in the jaw?	Yes	No	DK
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes	No	DK	Do you clench or grind your teeth?	Yes	No	DK
Does food or floss catch between your teeth?	Yes	No	DK	Do you wear dentures or partials?	Yes	No	DK
Is your mouth dry?	Yes	No	DK	Have you ever had a serious injury to your head or mouth?	Yes	No	DK
Have you had any periodontal (gum) treatment?	Yes	No	DK	Date of your last dental exam: _____			
Have you had any problems associated with previous dental treatment?	Yes	No	DK	What is the reason for your dental visit today? _____ _____			
Are you currently experiencing dental pain or discomfort?	Yes	No	DK	How do you feel about your smile? _____ _____			

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received and reviewed a copy of [AJ Dental, LLC]'s HIPPA Notice of Privacy Practices.

I understand that [AJ Dental, LLC]'s HIPPA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of [AJ Dental, LLC]'s revised HIPPA Notice of Privacy Practices upon request.

I understand that, if I have questions about [AJ Dental, LLC]'s HIPPA Notice of Privacy Practices, I may contact [Thales Lopes, 155 Main Street, Suite 400, Danbury, CT 06810. Phone #: 203-587-7999]

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that [AJ Dental, LLC] will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding [AJ Dental, LLC]'s privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask [Thales Lopes], noted above, for assistance.

X_____ _____
Signature of Patient — Date

X_____ _____
Signature of Personal Representative — Print name of Personal Representative

FOR OFFICE USE ONLY

[AJ Dental, LLC] made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices.* In spite of these efforts, [AJ Dental, LLC] was unable to obtain a signed Acknowledgement for the following reason(s):

☐ Refusal to sign Acknowledgement on_____, 20_____.
☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
☐ Other (Describe): _____

Patient ID	**Received by**	**Date**

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INFORMED CONSENT

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1. I hereby authorize the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request for a fee.

3. In general terms, the dental procedure(s) can include but not limited to:

- Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
- Application of resin "sealants" to the grooves of the teeth.
- Treatment of diseased, or injured teeth with dental restorations (fillings).
- Treatment of disease or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.
- **Extraction:** special consent given prior to procedure
- **Crowns and Bridges**: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I 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 the final opportunity to make changes in my new crown/bridge (including shape, fit, size, and color) will be before cementation.
- **Endodontic Treatment (Root Canal Therapy)**: I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
- **Periodontal Loss (Tissue & Bone):** I understand that periodontal disease is a serious condition, causing gum and bone infection or loss and that it can lead to loss of my teeth. Alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions.
- **Dentures, Complete or Partials**: I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems with wearing these appliances has been explained to me, including, looseness, soreness and possible breakage. I realize the final opportunity to make changes to my new dentures (including, shape, fit, size, placement & color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for these procedures are not included in the initial denture fees. I understand wearing dentures is difficult & there are common problems such as sore spots, altered speech and difficulty eating. Immediate dentures (placement of dentures immediately after extractions) may be painful, will require considerable adjustments & several relines and a permanent reline will be needed later; this is NOT included in the denture fee. It is important to make all necessary impression, try-in and delivery appointments, failure to make these appointments can result in poorly fitting dentures and the need to remake them, resulting in additional charges.
- **Fillings**: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common after-effect of a newly placed filling.

4. Drugs and Medications: I 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).

5. 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 once they've been discovered and discussed.

6. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. I further understand that this consent shall remain in effect until terminated by me.

X_____ _____

Signature of Patient or Parent/Guardian Date