

Aesthetic Dental
Jay E. Allen, DMD, MAGD
Drew Lawhorne, DDS
464 Montauk Avenue
New London, CT 06320
(860) 443-3634

We want to extend to you our personal greetings and a very warm welcome to **Aesthetic Dental**. We are accepting new patients, and we are committed to doing everything possible to provide you with high quality, state-of-the-art dental care and also to make your visit to our office as pleasant and as comfortable as possible.

The following information will be very useful to you:

- Our practice includes a wide range of dental procedures, including comprehensive dentistry, cosmetic dentistry, implant restorations, crowns, bridges as well as other esthetic and restorative procedures.
- At the time of your first appointment, we will listen closely to your concerns and conduct a thorough, comprehensive examination. We will take the time to give you the personal attention you deserve.
- Before any treatment begins, we will advise you of your options so you can make an informed choice regarding the best course of treatment for your specific needs. We respect our patients, and our goal is to provide you with the highest quality care in an atmosphere of mutual trust.
- Our practice is truly a family practice that is based on word-of-mouth referrals. We often treat many members of the same family, and some of our best patients are referred by some of our best patients.

Thank you for choosing Aesthetic Dental to serve your dental needs. If you have any questions, please feel free to call us at 860-443-3634. We will be looking forward to meeting you on «Appt_Date» at «Appt_Time».

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P.S. Please complete the enclosed medical/dental history questionnaire in the privacy of your own home and bring it with you to your first appointment. We need this information so that we can treat you safely.

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Financial and Appointment Guidelines

Thank you for choosing Aesthetic Dental for your dental care. Our team is eager to serve you and help you with your dental needs and concerns. We strive to make your dental experience with us comfortable and caring.

To ensure a good relationship, payment in full is expected at the time of service. We will be happy to assist you in filing a dental claim and determining what your optimal dental benefits might be. Your dental plan is a contract between you and your insurance company therefore, *we never* guarantee insurance benefits. Estimates of insurance payments by this office are subject to insurance company changes. The entire fee is the responsibility of the patient. We accept cash, checks, MasterCard, Visa, American Express and Discover cards. If you wish to apply for our extended payment plan with Care Credit please ask a member of our financial team for the details.

Appointments are the responsibility of the patient. We reserve time for you with our care providers and ask that you respect their time. Please notify us **AT LEAST** 48 hours in advance if you cannot make a scheduled appointment. Failure to notify us can result in a \$60.00 broken appointment fee.

We strive to give you and your family the best dental care possible and appreciate your help in making this relationship mutually successful.

Signed (Patient or Guardian)

Date

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Medical Health History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Name of Physician: _____ Phone: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Do you have or have you been treated for any of the following? Please check those that apply:

- Any Heart Problems
- Heart Attack
- Angina
- ByPass
- Pacemaker
- Stroke
- High Blood Pressure
- Low Blood Pressure
- Heart Murmur
- Mitral Valve Prolapse
- Heart Valve Defect
- Heart Valve Replacement
- Rheumatic Fever
- Artificial Joint (hip/knee)
- Bleeding Disorders
- Anemia
- Hemophilia
- Sickle Cell Trait
- Blood Transfusions
- Lung/Breathing Problems
- Asthma

- Bronchitis
- Migraines
- Emphysema
- Tuberculosis
- Sinus Trouble
- Diabetes
- Difficulty in Healing
- Liver Problems/Dysfunction
- Hepatitis/Jaundice
- Kidney Problems
- Tobacco use
- Alcoholism
- Drug Abuse
- Nervous or Mental Disorder
- Thyroid Problems
- Adrenal/Pituitary Problems
- Sexually Transmitted Diseases
- Epilepsy or Seizures
- Other infectious Diseases

- HIV/AIDS
- Cancer/Tumors
- Other Growths
- Chemotherapy/Radiation
- Rheumatic Fever
- Rheumatism
- Seizures
- HPV
- Stomach Problems
- Stroke
- Ulcers
- Allergies**
- Codeine Allergy
- Penicillin Allergy
- Erythromycin Allergy
- Sulfa Allergy
- Aspirin Allergy
- Local Anesthetic Allergy
- Latex Allergy
- Allergies _____

- OTHER:

- Smoker? If yes how many a day _____ How long have you smoked? _____
- Taking Medications?
List _____

- Natural/Herbal
Supplements: _____

- Pregnancy
Due date: _____

• Do you take antibiotic pre-medication prior to dental appointments? Yes No

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Dental History

Reason for this visit: _____

Name and address of last dentist: _____

Date of last dental visit _____

Have you ever had any complications following dental treatment? Yes No

If yes, please explain:

How often do you brush your teeth? _____ Floss? _____

What texture brush do you use? Soft Medium Hard Nylon Natural

Do your gums bleed while brushing? Yes No Do your gums bleed when flossing? Yes No

Do you avoid brushing or flossing any part of your mouth because of pain or swelling? Yes No

If yes, where? _____

Do you feel pain when your teeth come in contact with:

- Hot foods or liquids, i.e., soup, coffee, tea, etc.? Yes No
- Cold foods or liquids, i.e., ice cream cold fruit etc.? Yes No
- Sweets, i.e., candy, fruit, sweet desserts, etc.? Yes No
- Sours, i.e., Lemons, limes, grapefruit, etc.? Yes No

Do you chew on only one side of your mouth? Yes No

If yes explain

Do you clench or grind your teeth while sleeping or during the day? Yes No

Does your jaw ever feel tired? Yes No

Do you wear removable dentures or partials? Yes No

Do you usually have many cavities? Yes No

Do you lose fillings or break fillings? Yes No

Do you gag easily? Yes No

Are you familiar with the term "Preventive Dentistry"? Yes No

Have you ever thought about whitening your teeth? Yes No

Do you like the position, angle and shape of your teeth? Yes No

Have you ever thought about changing your smile? Yes No

Do you snore? Yes No

If you snore does it affect your sleeping partner? Yes No

Do you wake up tired or not rested in the morning? Yes No

Please add anything you feel is important

Patient Treatment Consent

I certify that the above information is complete and accurate.

I authorize the Dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such Diagnosis, I authorize the Dentist/staff to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist and mutually agreed upon by me.

I understand that the use of any photos, models or other images taken by either the dentist or designated staff may be used for diagnostic, educational or marketing purposes. I understand that my identity will be held confidential.

I agree to be responsible for payment of all services on my behalf or my dependents.

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

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the dentist. This form also authorizes this Dental Practice to submit insurance claim forms and receive payment directly from the Insurance carrier with the notation "Signature on file". I authorize my Dentist to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and /or requested.

I give my consent for my dependents to have treatment as deemed necessary if I am absent from dependent's appointment. I also agree that anyone I have chosen to bring my dependent to the Dentist has my permission to consent to whatever treatment is deemed necessary

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes their Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with notation "SIGNATURE ON FILE" I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and or requested.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____