Drs. Costello & Drake

ATLANTICDENTISTS.COM

Patient Information:

Patient's Name _____ M F Birthdate ___/___/_____ Age ____ Date ___/____/_____

Name you wish us to call you by: _____ Social Security # _____-____-_____ Spouse's Name:_____

Home Address: Street: _____ City:_____ State_____ Zip:_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email:_____Emergency Contact :_____ Phone: (_____) _____-_____

Patient Employer: _____ yrs ____ Spouse's Employer: _____ yrs_____

How did you find our practice? (please circle if applicable) Newspaper/Magazine Ad Internet Yellow Pages Complete Phone Book

If family, friend, co-worker or patient: Who? What did they say?_____

Dental Insurance Information:

Subscriber Name: _____ Date of Birth___/___/_____ SS# _____-____-_____

Relationship to Patient _____ Insurance Company: _____ Policy #: _____

Medical History and General Health:

Have you had any serious illness or operation? If yes, what? _____

When was the last time you were in the hospital? _____ For what? _____

Are you under any medical treatment now? **Y / N** If yes, for what? _____

Women: Are you pregnant? **Y / N** Taking birth control pills? **Y / N** (if yes, antibiotics may counteract) Hormones? **Y / N**

Are you **allergic** to Penicillin? **Y / N** Any other **allergies**? **Y / N** If yes, what? _____

Do you have or have you ever had the following? If yes, please check:

- ☐ Heart Valve Replacement If yes, when? ____ / ____
- ☐ Prosthetic Joint Replacement If yes, when? ____ / ____
- ☐ Facial Radiation Therapy If yes, when? ____ / ____
- ☐ High or Low Blood Pressure ____ / ____ If yes, are you taking medication? **Y / N** What? _____
- ☐ Anemia or Blood Disorder
- ☐ Arthritis
- ☐ Stroke
- ☐ Hepatitis (Type ____)
- ☐ Venereal Disease
- ☐ AIDS, ARC, HIV+
- ☐ Diabetes Taking Insulin Y / N
- ☐ Emphysema
- ☐ Kidney Trouble
- ☐ Persistent Cough
- ☐ Jaundice or Liver Disease
- ☐ Dizziness or Fainting
- ☐ Tumors or Growth
- ☐ Asthma, Hayfever or Sinusitis
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Convulsions
- ☐ Drug Addiction
- ☐ Do you smoke ? ____ Packs / day x ____ years = _____Pack Yrs
- ☐ Do you use smokeless Tobacco?
- ☐ Do you get enough Vitamins? Diet Supplement Both
- ☐ Do you take daily low dose aspirin?

Medications/purpose: _____

_____

Physician's Name _____ Phone Number: (_____) _____ - _____ Last visit: ____/ _____

Yes No Is there any disease, condition or health problem not listed above that we should know about? _____

_____

Patient Info provided by (please sign): _____ Date: ___ / _____

Pt Info updated:

2012_____; 2013_____; 2014_____; 2015_____; 2016_____; 2017 _____; 2018 _____; 2019 _____; 2020 _____

We endeavor to make your visits as pleasant as possible. Please tell your friends about your positive experiences!
Please fill out "Dental History" on reverse side and sign prior to proceeding with any treatment.

Dental History:

Yes No Do you have any specific dental concerns? Please explain:_____

_____

Yes No Have you had any serious trouble associated with any previous dental treatment? If yes, please explain:

_____

Previous Dentist Name:_____ Last visit _____ Last x-rays:_____

Yes No Are you unhappy with previous dental treatment/dentist? If yes, please explain: _____

_____

Yes No Do you have a specific fear of having dental work done? If yes, during dental treatment do you prefer:

Local anesthetic Y / N Nitrous Oxide Y / N Presedation (pill) Y / N IV Sedation Y / N

Yes No Have you been told you have Gingivitis/Periodontis? What year were you first told? _____; last told?_____

Have you been receiving preventive prophylaxis (no pockets over 4 mm) or corrective scaling? every _____months

Yes No Have you been referred to/treated by a Periodontist? When first referred?_____ When last treated? _____

Yes No Do your gums bleed? How often do you brush? ___ x a week How often do you floss? ___ x a week

Yes No Have you noticed an unpleasant taste/odor or any new/increasing spaces between/loosening of teeth?

Yes No Do you chew on only one side of your mouth? Left/Right Does this cause pain? Where?_____

Yes No Have you noticed yourself grinding/clenching your teeth? Does this cause pain? Where? _____

Yes No Have you been advised you have TMJ (bite/joint) problems? Have you even been treated for TMJ? Y /N

Yes No Are any of your teeth sensitive to cold, sweets or chewing/pressure? Where? _____

Yes No Are you unhappy with your teeth/smile? If yes, please complete a "Smile Analysis" form

Yes No Are you curious about BOTOX®/Dysport® or Juvederm®/Surgiderm® Fillers to smooth wrinkles?

Do you have sleep apnea? Y/N If so, do you wear a CPAP machine at night or other related appliance(s)? Y/N

What can we do to make your visits to our office more pleasant? _____

PRIORITY LEVEL OF CARE:

We believe it is appropriate for you to have an awareness of your overall Oral Health and the **PRIORITY LEVEL OF CARE** of indicated treatment necessary to improve and maintain your Oral Health.

Priority Level 1 Care: **IMMEDIATE NEED (Crisis Dentistry)**
pain; decay; broken/cracked tooth; broken/cracked/defective filling; periodontal disease

Priority Level 2 Care: **IMPENDING NEED (Need Based Dentistry)**
sensitive/cracked tooth; unsupported enamel; weak/corroded/oversize filling; occlusal wear into dentin

Priority Level 3 Care: **PREVENTIVE/IDEAL/OPTIMAL ORAL HEALTH CARE (Comprehensive Dentistry)**
cracked tooth (visual); craze lines; weak/corroded/oversize/old filling; worn teeth; collapsed occlusion/closed bite

Priority Level 4 Care: **COSMETIC DENTISTRY**

Bleaching; Recontour; Composite Bonding; Porcelain Veneers/Crowns; Replace dark fillings; BOTOX®/Dysport® or Juvederm®/Surgiderm®

We recommend completing Level 1 Care immediately and Level 2 Care as soon as possible, planning for completion of Level 3 Comprehensive Care Treatment on a timely basis, and proceeding with Level 4 Cosmetic Treatment if/when desired.

Please read & sign prior to any treatment:

I will not proceed with any treatment until I have all my questions regarding all options (including no treatment), complications, appointments or fees explained to my complete satisfaction. In order to minimize bookkeeping time and eliminate unnecessary fee increases, all fees for professional services are to be paid at time of treatment unless specific financial arrangements are made in advance. If I request an extended payment (plus interest) arrangement, I authorize obtaining Credit Bureau Reports. I authorize the performance of all procedures necessary in executing the treatment of the above named patient including the administration of anesthetics. I authorize the taking of and showing clinical photographs, and I take full responsibility for all financial obligations incurred. I hereby agree to pay any and all costs of collection for any amounts due, including attorney fees. I acknowledge receipt of notice of privacy practices.

Signature (Guardian if Patient is a Minor):_____

Method of Payment: ☐ Check ☐ Cash ☐ VISA/MasterCard/Discover/AmEx ☐ 3rd Party Financing

Fredrick W. Costello, DDS, MAGD, AAACD
Master Academy of General Dentistry
Accredited Member of American Academy of Cosmetic Dentistry
Past President Florida Academy of Cosmetic Dentistry

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Fellow International Congress of Oral Implantology
Certified in Conscious IV Sedation

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American Academy of Cosmetic Dentistry ACCREDITED MEMBER

Florida Academy of Cosmetic Dentistry Past President

Your Smile: Self Analysis *(optional)*

We would like to help you obtain the smile you've always wanted. If you are interested in obtaining a healthier, brighter smile, please fill out the form below.

1) Are you excited about your smile? ❒ Yes ❒ No

2) Are you pleased with the color and lack of discolored areas of your teeth? (If not, please ask about bleaching.) ❒ Yes ❒ No

3) Are you pleased with the shape and position of your teeth? (spacing, narrow, square, chipped, protruding, hidden, crowded, etc.) ❒ Yes ❒ No

4) Are you pleased with the appearance of your gums when you smile? ❒ Yes ❒ No

5) Are your two middle upper front teeth straight and slightly longer than adjacent teeth with softly rounded edges? (flat edges as a result of grinding your teeth may cause your smile to look "worn out" or old") ❒ Yes ❒ No

6) If your front teeth have fillings or old crowns, do they match the color and contour of your natural teeth? ❒ Yes ❒ No

7) Are your lower front teeth straight with even edges? ❒ Yes ❒ No

8) Are you pleased with your smile even if you have any unsightly fillings in the back of your mouth that show when you laugh or smile broadly? ❒ Yes ❒ No

9) Are you pleased with your overall smile and your facial appearance when you look in the mirror? ❒ Yes ❒ No

10) Are you happy with the appearance of your lips and how they complement your teeth when you smile? (lip fullness and volume is often considered a sign of youth) ❒ Yes ❒ No

11) Are you pleased with your smile even if you have facial wrinkles or lines? ❒ Yes ❒ No

On a scale of 1 (worst) to 10 (best), please rate your smile. ___
What would you like your smile to rate? ___

"No" answers and/or a disparity in how you rate your current smile compared to how you want your smile to rate indicate a need for a Cosmetic Consultation regarding smile improvement. You may or may not be ready for Priority Level IV Care (Cosmetic Dentistry) to improve your smile but you will know your options.

If you know of a family member or a friend who would benefit from a more attractive smile, do them a favor and suggest that they receive a Cosmetic Consultation. We will write them a Cosmetic Prescription outlining how their smile can be made more exciting; they can then discuss this with their current dentist, who, depending on his or her interest in Cosmetic Dentistry, may be very qualified to perform the indicated treatment. We will of course be delighted to perform the indicated Cosmetic Dentistry with the understanding that the patient may choose to return to their current dentist for general dentistry or choose to remain as a patient in our practice.

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Patient Information & Medical History for Botox®/Dermal Filler Treatment *(optional)*

Name: _____ *Date:* _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Phone: H: (_____) _____ - _____; W: (_____) _____ - _____; C: (_____) _____ - _____

*E-mail:*_____ *DOB:* ____/____/_____ *Age:* _____ *Sex: M / F*

Yes / No *Have you had any* BOTOX®*/Dysport® orJuvederm®/Surgiderm® Dermal Fillers before?*

Yes / No *If Yes, did you have any swelling/adverse reactions? If Yes, please explain:*

_____

Medical History *(please circle Yes or No, and explain Yes answers below)*

Yes / No Are you under the care of a physician? If yes, name, condition, contact info:_____

_____

Yes / No Do you currently have inflammation or infection in the treatment area?
Yes / No Are you allergic to any of the ingredients in BOTOX®/Dysport® or Juvederm®/Surgiderm®? (eg. Albumin/egg)
Yes / No Do you have any serious preexisting disease such as diabetes, congestive heart failure, uncompensated coronary artery disease, Rheumatoid arthritis, lupus or other?
Yes / No Are you a blood donor?
Yes / No Do you suffer from any diseases that affect your nerves and cause a generalized impairment of muscle strength? (i.e. Myasthenia Gravis, Eaton-Lambert Syndrome)
Yes / No Are you pregnant or planning to become pregnant soon; or currently breastfeeding?
Yes / No Are you currently taking antibiotics used to treat infections, such as gentamicin, tobramycin, clindamycin, or lincomycin?
Are you currently taking:
Yes / No steroids or non-steroidal anti-inflammatory drugs?
Yes / No medicines used to treat heart rhythm problems, such as quinidine; and anti-coagulants (Coumadin)?
Yes / No medicines used to treat different conditions, such as Myasthenia Gravis or Alzheimers disease?
Yes / No any over-the-counter medicines or herbal products that may interfere with the treatment?
Yes / No Do you have any “Ice pick” and other non-distensible scars, or widened surgical scars?
Do you have any:
Yes / No actinic damage of lips?
Yes / No previous serious reaction to hyaluronic acid derivatives?
Yes / No history of anaphylactic reactions or multiple severe allergies?
Yes / No product specific contraindications?
Yes / No history of hypertrophic or keloid scars?
Yes / No Do you have an important social function within the next week?

Please explain all Yes answers and list any other medications/supplements you are taking, current medical illnesses and known allergies to drugs/substances: _____

_____

What are your expectations of and desired outcomes for this treatment? _____

_____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature: _____ *Date:* ____ / ____ / _____