



Atlantic Center for Comprehensive Dentistry

Drs. Kraski, Costello & Drake

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 _____

Whom may we thank for referring you? _____ 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:

- | | | |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Heart Valve Replacement
If yes, when? ___ / ___ | <input type="checkbox"/> Prosthetic Joint Replacement
If yes, when? ___ / ___ | <input type="checkbox"/> Facial Radiation Therapy
If yes, when? ___ / ___ |
| <input type="checkbox"/> High or Low Blood Pressure ___ / ___
If yes, are you taking medication? Y/N What? _____ | | |
| <input type="checkbox"/> Anemia or Blood Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> AIDS, ARC, HIV+ |
| <input type="checkbox"/> Diabetes Taking Insulin Y/N | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Jaundice or Liver Disease | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Tumors or Growth | <input type="checkbox"/> Asthma, Hayfever or Sinusitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Drug Addiction |

Yes No Do you smoke? ___ Packs / day x ___ years = ___ PackYrs

Yes No Do you use smokeless Tobacco?

Yes No Do you get enough Vitamins? Diet Supplement Both

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:

2009 _____; 2010 _____; 2011 _____; 2012 _____; 2013 _____; 2014 _____; 2015 _____; 2016 _____; 2017 _____

**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 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 had any serious trouble associated with any previous dental treatment? If yes, please explain:

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

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 Do you chew ice or other abusive substances? Have you ever cracked or broken any teeth? Y / N
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 the form: "Your Smile: Self Analysis"
Previous Dentist Name:_____ Last visit _____ Last x-rays: _____
What did you like or dislike most about your previous dentist? _____
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 Zoom/Home \$____; Recontour U/L \$____; Composite Bonding \$____; Porcelain Veneers U/L \$____

We recommend completing Level 1 Care immediately and Level 2 Care as soon as possible, planning for the completion of Level 3 Comprehensive Care Treatment, 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

Henry E. Kraski, DDS, FICOI
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Certified in Conscious IV Sedation

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Your Smile: Self Analysis

We would like to help you obtain the smile you've always wanted. Please take a few minutes, while looking into a mirror, to complete this Smile Analysis.

- 1) Are you excited about your smile? Yes No
- 2) Are you pleased with the color of your teeth?
(If not, please ask about bleaching.) Yes No
- 3) Are you pleased with the shape and position of your teeth?
(narrow, square, chipped, protruding, hidden, crowded, etc.) Yes No
- 4) If there are spaces between your teeth, do you like them? Yes No
- 5) Are you pleased with the appearance of your gums when you smile? Yes No
- 6) Are your two middle upper front teeth straight and slightly longer
than adjacent teeth? Yes No
- 7) If your upper anterior teeth, esp. your cuspids, have flat edges
as a result of grinding your teeth (which might cause your smile
to look "worn out" or "old"), do you like the way your smile looks? Yes No
- 8) Are your teeth free of discolored areas? Yes No
- 9) If your front teeth have fillings or old crowns, do they match the color
and contour of your natural teeth? Yes No
- 10) Are your lower front teeth straight with even incisal edges? Yes No
- 11) If any old or unsightly fillings in the back of your mouth show when you
laugh or smile broadly, do you feel everything looks acceptable? Yes No
- 12) Are you pleased with the way your teeth fit together when you bite
and the shape or alignment of your jaws? 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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