CONFIDENTIAL PATIENT REGISTRATION

Date _____

Note: You must be at least 18 years old to complete this form.

At Streem, Resnick, Tetelman & Young DDS, Inc., our focus is on appearance-related dentistry, mouth rehabilitation and family dentistry. Our team of restorative dentists and dedicated hygienists takes care of your routine dental needs as well. With flexible payment plans, as well as phasing treatment over time, you and your family can achieve dental health, enjoy great smiles and keep your teeth for a lifetime. We are WHOLE LIFE DENTISTRY. Thank you so much for the opportunity to be of service.

Patient's name _____ Preferred Title ❑ Mr. ❑ Mrs. ❑ Miss. ❑ Dr. ❑ Ms.

Home Address _____ Send bills to: _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Preferred method of contact: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Text ❑ Email

Patient's SSN# _____ Patient's DOB _____ Age _____

Patient's occupation/position/school _____

Patient's Employer _____

Address _____

City _____ State _____ Zip _____

Patient Referred By _____

Name of Spouse _____ Occupation _____ Employer _____

Person financially responsible for this account (Guarantor) _____

Billing address (if different than above) _____

Dental insurance carrier _____ Group # _____

Subscriber's SSN# and/or I.D. # _____ Subscriber's DOB _____

Emergency Contact _____

IF YOU HAVE DENTAL INSURANCE, WE ARE HAPPY TO ASSIST YOU IN MAXIMIZING YOUR INSURANCE BENEFITS. AS A COURTESY WE WILL FILE CLAIMS TO YOUR INSURANCE COMPANY. WE ARE NOT RESPONSIBLE FOR ANY CLAIMS HANDLED BY AN INSURANCE COMPANY OR CORPORATE "FLEX-PLAN." ANY AND ALL FEES NOT PAID BY ANY THIRD PARTY BECOME THE GUARANTOR'S RESPONSIBILITY.

I hereby give permission to use the above information for the purpose of establishing an account, obtaining credit, and transmitting information to and from insurance carriers and other parties. I agree to be responsible for payment of all balances on this account. Balances over 90 days may be subject to interest. I give my permission to Drs. Streem, Resnick, Tetelman & Young to utilize any photos or images generated of my mouth, teeth or face for teaching, educational purposes or laboratory communication.

Signature _____ Date _____

WE RESPECT YOUR RIGHT TO CHOOSE THE LEVEL OF CARE THAT FITS *YOUR* NEEDS.

We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums - until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission, we would like to explain the choices available to achieve long-term health and beauty of your existing natural teeth. **Please check all that apply:**

- ❑ I desire to keep my own teeth for life, if possible. I want my teeth to look good and last for a very long time.
- ❑ Spreading payments out over time may help me to achieve the excellent results I desire.
- ❑ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- ❑ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- ❑ Although I am not interested in a plan for long-term dental health, I desire an office which will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

DENTAL HEALTH AND APPEARANCE

Why are you here today? _____

Approximate date of last dental visit _____ What was done at that visit? _____

What is your primary concern that you would like us to address first? _____

_____

When would you like us to start treatment? _____

Have you ever had a serious problem associated with previous dental treatment? _____

_____

What, if anything, has happened in previous experiences at the dentist that was a reason not to return? _____

_____

Do you have difficulty getting numb? _____

Does having a dental appointment make you anxious? _____

Do you have missing teeth? _____ If yes, have you had them replaced? _____

If you have had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____

What type of brush do you use? ❑ SOFT ❑ MED ❑ HARD ❑ ELECTRIC

Do you avoid brushing any part of your mouth because of pain? ❑ Yes ❑ No Where? _____

Are your teeth sensitive when you have a "cleaning"? _____

Does eating cause you twinges of pain? ❑ hot ❑ cold ❑ sweet ❑ chewing Where? _____

DENTAL HEALTH AND APPEARANCE continued

Have you lost or broken fillings? ❑ Yes ❑ No

Do you chew on only one side of your mouth? ❑ Yes ❑ No If yes, explain _____

Do your gums feel tender or swollen? ❑ Yes ❑ No

Do you usually have cavities? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No

Do your jaws ever feel tired or stiff? ❑ Yes ❑ No

Does your jaw joint click or pop? ❑ Yes ❑ No

Has your jaw ever locked open or closed? ❑ Yes ❑ No

Do you have headaches or migraines? ❑ Yes ❑ No

Have you had orthodontic treatment? ❑ Yes ❑ No When? _____

Have you had trauma or injuries to your head, face, jaws or teeth? If so, please describe _____

_____

_____

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____

Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = I love my smile) _____

Would you like to have whiter/brighter teeth? ❑ Yes ❑ No

If you had a magic wand what, if anything, would you change about your smile? _____

What personal or professional benefit might you gain if you had a better smile? _____

Do you have special occasions coming up? _____

Using state-of-the-art technology, we have the ability to help you achieve a world-class smile, often overnight...

With computer-assisted dental imaging and high resolution video photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge).

What would you like to change in your smile? Please check off any that apply:

❑ Lighten all front teeth	❑ Lighten a single tooth	❑ Close spaces between teeth
❑ Rebuild fracture(s)	❑ Lengthen teeth	❑ Shorten teeth
❑ Straighten rotation	❑ Straighten angulation	❑ Eliminate crowding
❑ Eliminate dark or stained fillings	❑ Reduce gum showing in smile	❑ Repair uneven edges

Please add anything else you feel is important _____

_____

FOR DOCTOR'S USE

CC/ITS

HPI

PMH

ROS

PERIO

CARIES

RESTORATIVE

BITE

TMJ

APPEARANCE

EXISTING PROSTHESIS

ANESTHESIA/SEDATION PLAN: ❑ LOCAL A B C D ❑ ANALGESIA ❑ SEDATION PO

INITIAL TREATMENT PLAN:

MAJOR CONCERN/MOTIVATING FACTORS