



Gregory D. Prieston, DDS PC • 5 Eversley Avenue • Norwalk, CT 06851 • 203-853-6626 • www.norwalkdentalcare.com

On behalf of the entire team at Norwalk Dental Care, let me welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average practice. When you visit our office you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequalled advanced training in cosmetic and reconstructive dentistry we have received. It is for these simple reasons that "We care about your care."

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed questionnaire that should be filled out prior to your first appointment with Dr. Prieston.

Be sure to visit our website at www.norwalkdentalcare.com or www.norwalkcosmeticdentist.com.

Yours truly for better dental health,

Gregory D. Prieston, DDS



REGISTRATION AND HEALTH HISTORY

Date: _____

First Name: _____ M.I. _____ Last Name: _____ male female Date of Birth: _____ Age: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____

Email Address: _____ Emergency Contact: _____

Marital Status: married single Student: full-time part-time N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Family Physician: _____ Phone#: _____

Dental Insurance Carrier: _____ ID#: _____ Group #: _____

Check this box **ONLY** if the Insured person (the person receiving dental service) is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS#: _____ Insured's Date of Birth: _____

Relationship to Insured: _____

Employer of Insured: _____ full-time part-time retired Phone#: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Who is financially responsible for this account? _____ Phone#: _____

Please select Y = Yes or N = No if you **have** any of the following conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N - Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N - Thyroid Disease | <input type="checkbox"/> Y <input type="checkbox"/> N - Seizure Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N - Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N - Kidney Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Heart Murmur (or MVP) | <input type="checkbox"/> Y <input type="checkbox"/> N - Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N - Venereal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N - High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N - Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N - Bleeding Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N - Are you nursing | <input type="checkbox"/> Y <input type="checkbox"/> N - Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Use Oral Contraceptives | <input type="checkbox"/> Y <input type="checkbox"/> N - Might you be pregnant | <input type="checkbox"/> Y <input type="checkbox"/> N - Aids/HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Artificial Joint / Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N - Hepatitis Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Y <input type="checkbox"/> N - Eating Disorders |
| <input type="checkbox"/> Y <input type="checkbox"/> N - History of Endocarditis | <input type="checkbox"/> Y <input type="checkbox"/> N - Radiation Therapy: Head / Neck | |

Other conditions not listed: _____

Are you allergic to latex, soy or egg products? _____

List any antibiotics, anesthetics or other drugs you are allergic to: _____

List all prescription medications you are presently taking: _____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your temporomandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? Yes No If yes, why? _____

Do you take aspirin on a daily basis? Yes No If yes, why? _____

Are you under a physician's care presently? Yes No If yes, why? _____

Have you ever been a drug or substance abuser? Yes No Do you smoke? Yes No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits unless otherwise indicated.

Signature: _____ Date: _____

Your signature indicates you have received a copy of the HIPAA law and Dental Material forms as well as releasing Dr. Prieston to utilize any dental photographs for lecturing or educational purposes.

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental 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 any serious problem associated with previous dental treatment or any dental emergencies? Yes No
If so, explain: _____

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

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

How often do you brush your teeth? _____ time(s) a _____ How often do you floss? _____ time(s) a _____

What type of brush do you use? Manual Powered

Do you avoid brushing any part of your mouth because of pain? Yes No If yes, what part? _____

Which foods cause you twinges of pain: Hot Cold Sweet Sour None

Do your gums feel tender or swollen? Yes No

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

Do you clench or grind your jaws while sleeping or during the day? Yes No Do your jaws ever feel tired? Yes No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? Yes No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome) _____

Would you like to have whiter teeth? Yes No

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

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight... Using Dental Imaging and Digital 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). Would you like to see what YOU would look like with a new and improved smile? Yes No **If yes, please select all that apply:**

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important:

At Norwalk Dental Care, though our focus is on appearance-related dentistry, our team also delivers routine general dental care as well. With flexible payment plans as well phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm Regards,

Gregory Prieston, D.D.S



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: _____ Telephone: _____ Social Security#: _____

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

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at 203-853-6626 or by mailing us at 5 Eversley Avenue, Norwalk, Ct 06851.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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Norwalk Dental Care

Gregory D. Prieston, DDS PC

5 Eversley Avenue ♦ Norwalk, CT 06851 ♦ (203) 853-6626

PAYMENT OPTIONS FOR OUR PATIENTS

For Optimum Health and Healthy Smiles

We believe it is important not only to provide the highest quality dental care, but to make this care affordable for our patients. Please ask us any question you may have. We are glad to be of assistance. We have made arrangements for our patients that allow payment to be convenient and flexible. We are committed to helping you receive the dental care you desire and the most pleasant dental experience possible.

1. **Payment in full at visit** with cash, check, or credit card (VISA, MasterCard, Discover or American Express)

For amounts over \$500, we offer a **5% courtesy** for payment in full when you receive treatment. We will gladly process any insurance claim for your direct reimbursement.

Adjusted fee: \$ _____ (savings: \$ _____)

2. **Estimated co-payment at visit** with cash, check, or credit card (VISA, MasterCard, Discover or American Express) with most insurance plans following benefit verification.

Estimated co-payment: \$ _____

Please be aware that we cannot guarantee this estimate and that there may be a balance after insurance pays. Whenever choosing this option, we ask that you leave a credit card on file for any balance that may be owed.

NOTE: Please see the form entitled, "Financial Agreement Pre-Authorization Form"

3. **No- or low-interest payment plans** for amounts over \$300 through CareCredit. We will gladly process any insurance claim for your direct reimbursement.

Monthly payment: \$ _____

Credit Report Authorization: I, _____ authorize Dr. Prieston to obtain my credit report in the event that I request a payment plan for my treatment.

Patient Signature/Guardian Signature

Date

Note to patients with insurance

We are happy to process any insurance claim as a service to you at no charge. Please keep in mind that any estimate that we provide to you is only an estimate and that you are responsible for all fees in their entirety. We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules, and are often above insurance allowances. You are fortunate to have dental insurance that may help you with the cost of treatment. If you may wish to complain to your company's benefits representative should your benefits be less than you expected.

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Delinquent accounts

Your account is considered delinquent if the requested payment is not received by the tenth (10th) of the month. If payment is not received, a late charge of 1 ½% per month (\$1.00 minimum) will be assessed. The annual percentage rate is 18%. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I have read and understand the financial options of Dr. Prieston and agree to the terms described in it.

Patient Signature/Guardian Signature

Date

COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other: _____

- We provide various levels of sedation to ease your mind.
Would you benefit from a sedative?..... Yes No

If yes, we provide: Nitrous Oxide (laughing gas)
 Mild sedative (oral medication)
(Note: With mild sedative, you will need someone to drive you to the appointment.)

- We now offer Oraverse, Oraverse is the first and only product to rapidly reverse the effects of your local dental anesthetic.
Would you be interested in learning more about it?..... Yes No
- Our treatment rooms are equipped with cable TV and DVD players. Watching TV or a movie is an excellent way to pass the time during your visit. Please let us know what your favorite movie or TV shows are, and at your next appointment we will make sure we have it for you to watch.

-
- We also have iPods for your use with personalized playlists.
Would you like to use an iPod during your visits?..... Yes No
Please provide a list of the artists or type of music you like so we can load them for your next visit.

-
- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?..... Yes No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?..... Yes No

- We also offer our patients a complimentary paraffin wax treatment during your visit.
Would you like to take advantage of this service?..... Yes No

- Is there anything else we can do to make your visit comfortable?

Please Handle Me With Care

Patient Name

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- I gag easily.
- I feel out of control when I'm lying down for a long time, and I feel uncomfortable about what you will say about my teeth and hygiene.
- Pain relief is a top priority for me.
- I don't like shots (or I've had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive.
- I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- Please respect my time. I don't want to be left sitting in the reception area.
- I want to know the cost up front.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.
- I am interested in conscious sedation (nitrous oxide with oxygen)
(Commonly called laughing gas, produces a mild sedation that is helpful in decreasing anxiety.)
- I am interested in oral sedation: for adults who need a deeper state of sedation

Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me, how each dental procedure will work, and how much of my time will be required.