To Our Valued Patients:

We would like to welcome you to our office. Please take a few moments to read the following with regard to our payment policy.

If you have no dental insurance, payment in full is required at the time of service.
If you have PPO dental insurance, we will be happy to bill your insurance company for you. Your estimated patient portion of the fee will be due at the time of service.

We are not currently contracted with any HMO or DPO plans or dental groups. If your insurance is with an HMO or DPO plan, we will consider your account with us as "cash" and payable at the time of service.

Please understand that we cannot always discern from your insurance card the exact plan in which you are enrolled or the exact benefits that you are eligible for. You will need to be familiar with your dental coverage specifics. We always welcome questions and are available to help you understand your insurance if we can. If you need to make financial arrangements, please speak with us prior to your appointment time.

We request a **48 hours notice** if you need to cancel or reschedule your dental appointments. Broken appointment fees with less than 48 business hours notice (not including Fridays) or "no show" appointments will be charged the rate of **$75 per hour** reserved.

Initials

__________ I have read and understand the above material and agree to its standards.

__________ I have received the Notices of Privacy Practices.

__________ I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs/my child's dental needs.

__________ I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administration claims for insurance benefits. 1, the undersigned, grant permission to Newbury Park Dental Arts and Dr. Cristina Markiewicz to utilize my x-rays and/or photos for advertisement, social media & educational purposes as needed.

Patient Name: ______________________________

SIGNATURE OF PATIENT,
PARENT OR GUARDINAN ______________________ **DATE:** __________

Printed Name: ______________________________

Newbury Park
DENTAL ARTS

Welcome to a whole new level of oral health care! Our practice is like no other you have ever been to. We are a general dental office that focuses on comprehensive care. We believe in helping our patients develop a personalized oral health plan that will help them improve their overall health and optimize their oral health for their lifetime. So that we can best serve you and your specific needs, we ask you to complete these comprehensive forms.

PERSONAL INFORMATION

Name: ______________________

Address: ______________________

City: ____________ State: ________ Zip: ________

Home Phone: ____________ Cell: ____________

E-mail: ______________________

Birthdate: ____________ Age: ____________

Occupation: ______________________

Employer: ______________________

Business Address: ______________________

City: ____________ Business phone: ____________

Person responsible for this account: ______________________

Is another member of your family a patient at our office? Yes ☐ No ☐

Whom may we thank for referring you? ______________________

Person to contact for an emergency? ______________________

Emergency contact phone # ______________________

Appointments are confirmed via (please check your preference)

☐ Text message
☐ e-mail
☐ Both

INSURANCE INFORMATION

Primary Carrier

Insurance Company: ______________________

Address: ______________________

Employer: ______________________

I.D.#: ______________________

Group#: ______________________

Relationship to insured: ______________________

Insured SSN: ______________________

Insured Birthdate: ______________________

Your SSN (if different): ______________________

Secondary Carrier

Insurance Company: ______________________

Address: ______________________

Employer: ______________________

I.D.#: ______________________

Group#: ______________________

Relationship to insured: ______________________

YOUR SPOUSE INFORMATION (for insurance reasons)

Name: ______________________

Occupation: ______________________

Employer: ______________________

Business Address: ______________________

Business City: ______________________

Business Phone: ____________ Cell: ____________

MEDICATIONS List all medications, prescription and non-prescription that you are currently taking:

Name:	Dosage:	Reason:

SIGNATURE OF PATIENT,
PARENT OR GUARDINAN ______________________ **DATE:** ____________

MEDICAL HISTORY

Please check YES or NO for each history question.

Question			
Are you under a physician's care now?	☐ YES	☐ NO	if yes, please explain ______
Have you ever been hospitalized?	☐ YES	☐ NO	if yes, please explain ______
Have you ever had a major operation?	☐ YES	☐ NO	if yes, please explain ______
Are you taking any medications, pills, drugs?	☐ YES	☐ NO	if yes, please explain ______
Have you ever taken Phen-Fen or Redux?	☐ YES	☐ NO	if yes, please explain ______
Have you ever taken Fosomax, Boniva, Actonel or any other medications containing Bisphosphonates?	☐ YES	☐ NO	if yes, please explain ______
Have you ever had a serious head/neck injury?	☐ YES	☐ NO	if yes, please explain ______
Are you on a special diet?	☐ YES	☐ NO	if yes, please explain ______
Do you use tobacco?	☐ YES	☐ NO	if yes, please explain ______
Do you use controlled substances?	☐ YES	☐ NO	if yes, please explain ______

Women: Are you :

Pregnant / Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Are you allergic to any of the following? (please check all that apply)

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Other:

Do you have, or have you ever had any of the followig:

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	☐ yes ☐ no	Cortisone Medicine	☐ yes ☐ no	Heart Disease	☐ yes ☐ no	Radiation Treatment	☐ yes ☐ no
Alzheimer's Disease	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Heart Trouble	☐ yes ☐ no	Renal Disease	☐ yes ☐ no
Anaphylaxis	☐ yes ☐ no	Dialysis	☐ yes ☐ no	Hemophilia	☐ yes ☐ no	Rheumatic Fever	☐ yes ☐ no
Anemia	☐ yes ☐ no	Dizziness	☐ yes ☐ no	Hepatitis A	☐ yes ☐ no	Rheumatism	☐ yes ☐ no
Angina	☐ yes ☐ no	Drug Addiction	☐ yes ☐ no	Hepatitis B or C	☐ yes ☐ no	Scarlet Fever	☐ yes ☐ no
Arthritis/Gout	☐ yes ☐ no	Easily Winded	☐ yes ☐ no	Herpes	☐ yes ☐ no	Shingles	☐ yes ☐ no
Artificial Heart Valve	☐ yes ☐ no	Emphysema	☐ yes ☐ no	High Blood Pressure	☐ yes ☐ no	Sickle Cell Disease	☐ yes ☐ no
Artificial Joint	☐ yes ☐ no	Epilepsy or Seizure	☐ yes ☐ no	Hives or Rash	☐ yes ☐ no	Sinus Trouble	☐ yes ☐ no
Asthma	☐ yes ☐ no	Excessive Bleeding	☐ yes ☐ no	Hypoglycemia	☐ yes ☐ no	Spina Bifida	☐ yes ☐ no
Blood Disease	☐ yes ☐ no	Excessive Thirst	☐ yes ☐ no	Irregular Heartbeat	☐ yes ☐ no	Stomach Disease	☐ yes ☐ no
Blood Transfusion	☐ yes ☐ no	Fainting Spells	☐ yes ☐ no	Kidney Problems	☐ yes ☐ no	Intestinal Disease	☐ yes ☐ no
Breathing Problem	☐ yes ☐ no	Frequent Cough	☐ yes ☐ no	Leukemia	☐ yes ☐ no	Stroke	☐ yes ☐ no
Bruise Easily	☐ yes ☐ no	Frequent Diarrhea	☐ yes ☐ no	Liver Disease	☐ yes ☐ no	Swelling of Limbs	☐ yes ☐ no
Cancer	☐ yes ☐ no	Frequent Headaches	☐ yes ☐ no	Low Blood Pressure	☐ yes ☐ no	Thyroid Disease	☐ yes ☐ no
Chemotherapy	☐ yes ☐ no	Genital Herpes	☐ yes ☐ no	Lung Disease	☐ yes ☐ no	Tonsillitis	☐ yes ☐ no
Chest Pain	☐ yes ☐ no	Glaucoma	☐ yes ☐ no	Mitral Valve Prolapse	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Cold Sores	☐ yes ☐ no	Hay Fever	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no	Tumors or Growths	☐ yes ☐ no
Convulsions	☐ yes ☐ no	Heart Attack/Failure	☐ yes ☐ no	Pain in Jaw Joint	☐ yes ☐ no	Ulcers	☐ yes ☐ no
Congenital Heart Disorder	☐ yes ☐ no	Heart Murmur	☐ yes ☐ no	Parathyroid Disease	☐ yes ☐ no	Venereal Disease	☐ yes ☐ no
		Heart Pace Maker	☐ yes ☐ no	Psychiatric Care	☐ yes ☐ no	Weight Loss/Gain	☐ yes ☐ no
						Yellow Jaundice	☐ yes ☐ no

Have you ever had any serious illness not mentioned here? Explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDINAN ______________________ **DATE:** __________

Newbury Park
DENTAL ARTS

DENTAL HISTORY

please indicate an answer for each general question

How often do you brush? ______________________ How often do you floss? ______________________

Toothpoaste you use: ______________________ Mouthwash you use: ______________________

Other oral health care aids you currently use (waterpik, electric toothbrush, tongue scraper, etc.)

____

Date of last Dental Exam: ______________________ Date of last clening: ______________________

Do you currently have any dental pain? ☐ YES ☐ NO if yes, where: ______________________

if yes to above, is this pain: ☐ Sporadic ☐ Constant ☐ Dull ☐ Sharp

Do you have any other current dental concerns / Comments ?

Do you now, or have you ever (Please select)

Grind Teeth:		Bite Nails:	
Bite Cheek:		Smokeless Tobacco:	
Tongue Thrust:		Thumb / Finger:	
Mouth Breather:		Toothpick / Stimulator:	
Bulimia/ Anorexia:		Chewing Gum:	
Cigar / Cigarette:		Candy:	
Pipe:		Soft Drinks:	

Are your teeth senitive to: (please select)

Hot or Cold:	
Biting / Chewing:	
Sweets:	

Have you ever had: (please select)

Orthodontic Treatment:	
A bite plate of guard:	
Periodontic Treatment:	
Oral Surgery:	
Serious injury to mouth or head	

Is there anything about your teeth or smile that you dont like or would like to change?

Is there anything else about your teeth or dental history that you want us to know?

CONSENT FOR MYSELF OR MINOR PATIENT:
The undersigned hereby authorizes Dr. Markiewicz and employees to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Markiewicz to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Markiewicz to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with above referenced patient and further authorize and consent that Dr. Markiewicz choose and employ such assistance she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

SIGNATURE OF PATIENT,
PARENT OR GUARDINAN ______________________ **DATE:** __________ **WITNESS:** __________

Newbury Park
DENTAL ARTS

TMJ AND SLEEP SCREENING FORM

Check all that apply:

- ☐ Frequent Snoring
- ☐ Sleep Apnea
- ☐ Daytime Fatigue
- ☐ Told that I “stop breathing” during sleep
- ☐ Headaches and/or Migraines
- ☐ Ear Congestion
- ☐ Pain Behind the Eyes
- ☐ Vertigo (dizziness)
- ☐ Tinnitus (ringing in the ears)
- ☐ Limited Mouth Opening
- ☐ Neck, Shoulder or Back Pain and/or
- ☐ Stiffness
- ☐ Loose Teeth
- ☐ Clenching / Bruxing
- ☐ Clicking or Grating Sounds in Jaw Joint(s)
- ☐ Pain or Soreness of Jaw Joint(s)
- ☐ Locking Jaw (opened or closed)
- ☐ Tender, Sensitive Teeth
- ☐ Thermal Sensitivity (hot or cold)
- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Trigeminal Neuralgia
- ☐ Bell’s Palsy
- ☐ Postural Problems
- ☐ Tingling or Numbness in Fingers or Arms
- ☐ Nervousness / Insomnia

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

☑ Check one in each row:	**0 No chance of dozing**	**1 Slight chance of dozing**	**2 Moderate chance of dozing**	**3 High chance of dozing**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e., a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: ______________ (Add Columns 0-3)

Newbury Park
DENTAL ARTS

Name: ______________________ **Date:** ______________

DENTAL COSMETIC QUESTIONNAIRE

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions, circle any words that may apply, and provide us with any additional information.

How do you rate your smile on a scale of 1-10 with 10 being the best smile? 4

When I see a picture of myself, the first thing I notice about my smile is:

Do you like the color of your teeth? (dark, dull, stained, mismatched?)

Do you feel that your teeth are too small or too short?

Do you feel that your teeth are too large or too long?

Are your teeth crooked or out of line?

Are there spaces between your teeth you don't like?

Do you show a lot of gum tissue when you smile?

Are your gums irregularly shaped (higher or lower on some teeth)?

Are the biting edges of your teeth uneven, worn down, or chipped?

Do your teeth slant one way or another?

Is the midline of your upper two front teeth centered with your nose?

Have your gums receded?

Are there any dental fillings or crowns that don't match your teeth or look ugly?

Are any of your teeth missing?

Do you feel that your smile is too narrow?

Do you feel that you don't show enough teeth when you smile?

Is there anything else about your smile or teeth that you don't like, would like to change, or would like us to know about?

Newbury Park
DENTAL ARTS

Our office is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability . . . thank you!

What is the main purpose of your first visit and what would you like to get accomplished?

Briefly mention any positive or negative aspects of your previous dental visits

What do you already know about our office and what are your expectations?

TREATMENT RECOMMENDATIONS OR TREATMENT OPTIONS?

Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you, please rate on the following scale from 10 to 1.

1. How (dental) healthy would you like to be?

10 9 8 7 6 5 4 3 2 1

10 (healthiest) *1 (not a concern at this time)*

2. Almost all dental problems are predictable and preventable. In order to not overwhelm you with excess details, how preventative (or proactive) would you like to be regarding dental disease?

10 9 8 7 6 5 4 3 2 1

10 ("nip in the bud early") *1 (wait until it hurts)*

3. How important are dental cosmetics to you?

10 9 8 7 6 5 4 3 2 1

10 (very important) *1 (not important)*

Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.

4. How important is facial cosmetics to you?

10 9 8 7 6 5 4 3 2 1

10 (healthiest) *1 (not a concern at this time)*

5. Anything else you would like to mention ?