dallasprosthodontics
specialists in prosthodontics

6029 Beltline Road, Suite 120, Dallas, TX 75254 • Phone: 972-503-7200 Fax: 972-503-7276 Answered 24 Hour

DATE: _____

Last Name:			Middle Initial:	First Name:
Birthdate:	☐ male	☐ female		SS #:
Marital status:	☐ married	☐ single	☐ divorced ☐ seperated	☐ widowed
Occupation:		Employer:		Spouse's name:
Home Address:				
City/State:		Zip:	Email Address:	
Home phone #:		Work phone #:		Other contact#:
Previous/Current dentist:				
Name and Address of Physician:				
Referred by:				
Reason for making appointment:				
Name/Address and phone # of nearest living relative:				

DENTAL HISTORY: (circle "Yes", or "No", or if in doubt, circle "DNK" for Do Not Know)

1. How would you describe your dental health?	Excellent	Good	Fair	Poor
2. Is your present oral hygiene effective in cleaning your teeth?	Yes	No	DNK	
3. Have you ever had orthodontic braces?	Yes	No	DNK	
4. Are you satisfied with the way your teeth look?	Yes	No	DNK	
5. Are your teeth sensitive to: hot cold sweetness pressure toothbrush				
6. When were your teeth last cleaned? _____				
7. If known, date of last set of complete dental x-rays? _____				
8. Have you had an unfavorable experience in a dental office?	Yes	No	DNK	
9. Have you had previous gum trouble?	Yes	No	DNK	
10. Have you had a deep cleaning in the past?	Yes	No	DNK	
11. If yes, what was treated and by whom? _____				
12. Would the loss of a tooth (or teeth) disturb you?	Yes	No	DNK	
13. What concerns you most about your mouth? _____				
14. Do you use mints, hard candies etc. regularly?	Yes	No	DNK	
15. Do you have a snoring problem?	Yes	No	DNK	
16. Do you have dry mouth?	Yes	No	DNK	

ISSUES ABOUT YOUR BITE AND/OR JAW JOINT

1.	Are you aware of a tired feeling in your face?	Yes	No	DNK
2.	Do you have ringing or pain in your ears?	Yes	No	DNK
3.	Do you clench or grind your teeth?	Yes	No	DNK
4.	Do you have frequent headaches?	Yes	No	DNK
5.	Do you have pain around your ears, eyes, head, and/or neck?	Yes	No	DNK

GENERAL HEALTH

1.	Do you have any type of health problem?	Yes	No	DNK
2.	Do you have high blood pressure?	Yes	No	DNK
3.	Do you have low blood pressure?	Yes	No	DNK
4.	Do you have shortness of breath after climbing a flight of stairs?	Yes	No	DNK
5.	Do you bleed for more than 30 minutes for a minor cut?	Yes	No	DNK
6.	Are you taking any medication? If so please list them & explain why you are taking them:			

_____

_____

_____

7.	Have you been hospitalized in the last 5 years?	Yes	No	DNK
	If yes, please explain: _____			
8.	Do you faint easily or experience dizziness?	Yes	No	DNK
9.	Have you taken cortisone/steroids in the last 6 months?	Yes	No	DNK
10.	Have you been under the care of a physician in the last year for reasons other than a routine physical examination?	Yes	No	DNK
11.	Have you had a major illness/serious operation in the last 5 years?	Yes	No	DNK
	If yes, please explain: _____			
12.	Have you had rheumatic fever?	Yes	No	DNK
13.	Do you have any type of artificial joint/heart valve/pacemaker in place?	Yes	No	DNK
	If so, please explain: _____			

14. Please circle an allergy to any of the following medications:

Penicillin	Keflex/ Keflin	Xylocaine	Phenaphen	Tylenol	Morphine	Sulpha
Erythromycin	Vibromycin	Novocaine	Codeine	Valium	Versed	
Tetracycline	Carbocaine	Aspirin	Percodan	Demerol	Phenergan	

List any others: _____

15. Please estimate the number of glasses/cups you consume on an average day:

Coffee _____ Tea _____ Soft Drinks _____ Alcoholic Beverages _____

16	Do you smoke?					Yes	No DNK
	If so, circle:	Cigarette	Cigar	Pipe	Betel Nut	Chewing Tobacco	
	How many in the average day: _____						
17.	Have you ever had an unusual reaction to Dental Anesthesia?					Yes	No DNK
18.	Do you have a latex allergy (gloves) or any metal allergies?					Yes	No DNK

FAMILY HISTORY: (Please circle)

1.	Have any family members (blood kin) had heart disease, high blood pressure, or diabetes?	Yes	No	DNK
2.	Have any family members (blood kin) suffered complete tooth loss?	Yes	No	DNK

MEDICAL HISTORY: (Do you now have, or have you ever had)			
1. Do you need to pre-medicate before dental appointment?	Yes	No	DNK
If yes, what do you take: _____			
2. Blood Disorders (anemia, leukemia)?	Yes	No	DNK
3. Frequently swollen ankles?	Yes	No	DNK
4. Stomach ulcers?	Yes	No	DNK
5. Excessive thirst or hunger over an extended period of time?	Yes	No	DNK
6. Change in urination frequency?	Yes	No	DNK
7. Cuts which tend too heal slowly?	Yes	No	DNK
8. Diabetes – Insulin or non Insulin Dependent?	Yes	No	DNK
9. Thyroid disturbance, or taken thyroid tablets? (Hypo or Hyper)	Yes	No	DNK
10. Do you have shortness of breath?	Yes	No	DNK
11. Hepatitis A, B or C?	Yes	No	DNK
12. AIDS or AIDS-related complex or positive for the AIDS virus?	Yes	No	DNK
13. Kidney or bladder disease/problems?	Yes	No	DNK
14. Stroke?	Yes	No	DNK
15. Arthritis or rheumatism?	Yes	No	DNK
16. Venereal disease (syphilis, ghonorrhea, herpes, HPV)?	Yes	No	DNK
17. Epilepsy, convulsions, or seizures?	Yes	No	DNK
18. Cancer or radiation therapy?	Yes	No	DNK
19. Any heart problems (mitral valve prolapse or a heart murmur)?	Yes	No	DNK
20. Nervous breakdown or psychotherapy?	Yes	No	DNK
21. Are you taking any sort of tranquilizers?	Yes	No	DNK
22. Are you taking any anticoagulants (blood thinners)?	Yes	No	DNK
23. Are you taking any antacids regularly?	Yes	No	DNK
24. Are you taking any mood elevators?	Yes	No	DNK
If so, please list: _____			
25. Glaucoma?	Yes	No	DNK
26. Asthma, hay fever, or eczema?	Yes	No	DNK
27. Do you use an inhaler?	Yes	No	DNK
28. Males only: Prostate problems?	Yes	No	DNK
29. Females only: Are you pregnant?	Yes	No	DNK
Are you taking birth control pills/other hormones?	Yes	No	DNK
30. Have you ever taken Phen Phen or Redux?	Yes	No	DNK
31. Have you ever taken Fossomax?	Yes	No	DNK
32. Have you ever taken Bone Replacement Therapy?	Yes	No	DNK

* Do you have any disease, condition, or problem not listed above that you think we should know about that you believe may affect treatment in any way? _____

_____

Patient or Guardian Signature: _____ Date: _____

Our Privacy Policy Guidelines:

In our efforts to comply with the Health Information Privacy Act, HIPAA, we need to be certain that we guard your medical and dental information to the best of our ability. Please read, initial, and date the following so that you will be informed of how we will use your information.

APPOINTMENT CONFIRMATION:

By initialing the following, you are giving us permission to leave a message either at home or at work to confirm your appointments the day before they are scheduled.

Initial: _____ Date: _____ Preferred Number to call: _____

REFERRING DOCTOR OR DOCTOR TO BE REFERRED TO:

By initialing the following, you are allowing us to contact a referring doctor and discuss your treatment with their office or contact a doctor that we would like to refer you to and give them any information they may need in order to properly treat you.

Initial: _____ Date: _____

INSURANCE CLAIM PROCESSING:

Dr. Rowan Buskin and Dr. Paulino Castellon do not accept insurance for payment of treatment. You, the patient, is responsible for payment of treatment at the time of service. We will however, fill out all necessary forms to send into your insurance provider to ensure prompt claim processing.

By initialing the following, you are allowing us to send information to your insurance carrier for claim processing.

Initial: _____ Date: _____

DENTAL LAB WORK:

By initialing the following, you are allowing us to transfer information to our dental technicians regarding treatment for you.

Initial: _____ Date: _____

PRIVACY POLICY:

By initialing the following, you are accepting our privacy policy as written.

Initial: _____ Date: _____

I have read and understand each of the items listed above.

Signature: _____ Date: _____

Radiograph Policy In Accordance With State Practice Guidelines

In accordance to the guidelines of the Texas Occupations Code for Dentistry and by following the Standard of Care for our patients, Drs. Buskin and Castellon will complete a yearly exam on each patient as they are seen for their dental cleanings. At each exam, Drs. Buskin and Castellon evaluates the mouth for:

1) Tooth decay, fractures, or areas of enamel demineralization/weakening
2) Current integrity of existing restorations and need for replacement
3) Pathologies of the oral tissues and abnormal lesions
4) Existing bone, bone loss, and joint problems

In order for our office to provide this Standard of Care and for Drs. Buskin and Castellon to complete a thorough, yearly exam, we will need to have radiographs of the oral cavity that will help ensure no potential issues are left undiagnosed.

Drs. Buskin and Castellon will have only a limited understanding of the current condition of your mouth by directly viewing your teeth during an exam. In other words, early detection of any problem is best for your overall health and is made possible by utilization of radiographs.

Please understand that the benefits of dental x-rays outweigh the potential hazards, for example, if there were a missed diagnosis of a jaw tumor that could be malignant or tooth decay that could develop into root canal and crown treatment, these problems could result in dental bills and pain that was avoidable.

At our office, we share your concerns about x-radiation. This is why we follow strict standards when exposing radiographs, including:

1) Utilization of lead vests for your protection
2) Use of digital radiography, which reduces normal exposure by 1/2 to 1/3
3) Avoiding radiation to expectant mothers unless a dental emergency is present
4) Only taking check up x-rays on a yearly basis and taking panoramic or full mouth series of films every 3-5 years

If Drs. Buskin and Castellon have prescribed their staff to take radiographs, then they believs that radiographs are a necessary prerequisite for your proper dental care.

Signature: _____ Date: _____

Written Financial Policy

Thank you for choosing Rowan Buskin, BDS. MSc. and Paulino Castellon DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1000 or more.
- NO INTEREST [1] Payment Plans [2] from CareCredit
  - Allow you to pay over time with NO INTEREST [1]
  - Convenient, low monthly payment plans [2] also available
  - No annual fees or pre-payment penalties

Please note:

Rowan Buskin, BDS. MSc. and Paulino Castellon DDS. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds. For plans requiring multiple appointments, alternative payment arrangements may be provided.

We also offer in-house financing.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

A fee of $40 per hour missed is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.
Rowan Buskin, BDS. MSc. charges Bank fees for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2] Subject to credit approval.