James H. Doundoulakis, D.M.D., M.S

Cosmetic Dental Rehabilitation PC
53 East 66th Street
New York, NY 10065
Telephone: (212) 517-3365

Cosmetic Dental of Greenwich PLLC.
1 Webb Avenue
Old Greenwich, CT 06870
Telephone: (203) 344-9523

PATIENT INFORMATION

Date: _____ Home Phone _____

Name:_____ Soc. Sec. #_____
Last Name First Name Initial

Address_____

City _____

Sex: □ M □ F Age_____ _____Birth Date_____/_____/_____ Marital Status_____

EMAIL_____ Cell # _____

Employer_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

In case of an emergency who should be notified?_____ ____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last name First name Initial

Relation to Patient _____ Birthdate_____Soc.Sec.#_____

Employer _____ Occupation_____

Insurance Company_____Ins. Group#_____Tel.#_____

It is important that we know about your Medical & Dental History. These facts have a direct bearing on you Dental Health. This information is strictly confidential. Thank you for taking the time to complete this information.

DENTAL HISTORY	**Medical History**	**YES**	**NO**
How long since you have seen a Dentist?_____	Do you have **CURRENT** health problems?	☐	☐
Last Full Mouth X-Rays Date?_____	Are you under a PHYSICIANS CARE Now?	☐	☐
Last Dental Exam_____	For **what?** _____		
Reason for today's visit?_____	What Medications are you taking now? _____		
	_____		
Are you having problems now? _____	Do you smoke? _____	☐	☐

	Yes\ No
Is your present dental **HEALTH** poor	☐ ☐
Do you have **bad breath?**	☐ ☐
Do you wear **DENTURES**?	☐ ☐
Are you **unhappy** with your Dentures? (partial or full)	☐ ☐
Would you like to know more about **Permanent tooth Replacements**?	☐ ☐
Are you Apprehensive about dental treatment?	☐ ☐
Have you had any Periodontal **(GUM)** Treatments or Surgery	☐ ☐
Are your gums **TENDER** OR **IRRITATED?**	☐ ☐
Are your teeth sensitive to hot, colds, Sweets or pressure? (circle)	☐ ☐
Are you unhappy with the Smile?	☐ ☐
Are you aware of **GRINDING** and **CLENCHING** of your teeth?	☐ ☐
Do you have **HEAD,EARACHES** or **NECK** pains?	☐ ☐
Have you worn **BRACES**?	☐ ☐
Do you regularly use **DENTAL FLOSS**?	☐ ☐

Name of Previous Dentist_____
City_____ State: _____

PATIENT SIGNATURE (PARENT OR GAURDIAN)

X _____

Circle ANY OF THE FOLLOWING WHICH You HAVE HAD\ Or presently have:

Heart Disease or Attack	Angina Pectoris
High Blood Pressure	Heart Murmur
Rheumatic Fever	Congenital heart
Lesions	Artificial Heart Valve
Mitral Valve Prolapse	Heart Surgery
Artificial Joints(hip or Knee)	Anemia
Stroke	Kidney Trouble
Ulcers	
A.I.D.S/ A.R.C/HIV pos.	Liver Disease
Hepatitis (A infectious)	Drug Addiction
Blood Transfusion	Nervousness
Hemophilia(Bleeding Problems)	Fever Blisters
Epilepsy or Seizures	Glaucoma
Psychiatric Treatment	Hepatitis C
Chemotherapy (cancer, leukemia)	
Bisphosphonate Drugs (Boniva, Aredia, Zometa,Fosamax)	
Venereal Disease(syphilis Gonorreha etc.)	
Bruise easily	Emphysema
Tuberculosis	Asthma
Radiation Trouble	Sinus Trouble
Allergies or hives	Diabetes
Thyroid Disease	Hay Fever
Cortisone Medicine	Alcoholism
Pain in Jaw Joints	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS

ASPIRIN , LOCAL ANESTHESIA ERYTHROMYCIN

NITROUS OXIDE CODEINE PENICILLIN

ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATIONS or SUBSTANCES?_____
_____

IF YES PLEASE LIST:_____
_____

IS THERE ANY OTHER MEDICAL/DENTAL INFORMATION THAT YOU FEEL WE SHOULD KNOW ABOUT?
_____

COMPLETED TREATMENT COSMETIC DENTAL OF NY AND GREENWICH

A B C D E	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	F G H I J
	RIGHT	LEFT	
T S R Q P	32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	O N M L K

INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMATION: SLIGHT MODERATE SEVERE
SOFT PLAQUE BUILDUP: SLIGHT MODERATE HEAVY

HARD CALC. BUILDUP: LIGHT MODERATE HEAVY
STAINS: LIGHT MODERATE HEAVY
HOME CARE EFFECTIVENESS: GOOD FAIR POOR
PERIODONTAL CONDITION: GOOD FAIR POOR
PERIODONTAL DIAGNOSIS: NORMAL GINGIVITIS
PERIODONTITIS EARLY MODERATE ADVANCED
MUCOGINGIVAL DEFTECTS #S:_____

INITIAL -XRAY FINDINGS:

X-RAYS TAKEN: FM-PAS BWX PANO OTHER _____

____ NO BONE LOSS
____ SLIGHT BONE LOSS (04600)
____ MODERATE BONE LOSS (04700)
____ MAJOR BONE LOSS (04800)
____ BEGINNING FURCATION (04700)
____ ADVANCED FURCATION (04800)

QUADRANTS

UR	UL	LR	LL

_____ OTHER _____

CLINICAL DATA:

OCCLUSION: CLASS I CLASS II CLASS III CROSSBITS _____
T.M.J EXAM: NORMAL POPPING DEVIATION TOOTWEAR PAIN

REFERALLS:

PERIO _____ ORTHO: _____ ENDO_____
ORAL SURG _____ M.D. _____ OTHER _____

INITIAL SOFT TISSUE EXAM:
LIPS FLOOR OF MOUTH PALATE TONGUE NECK & NODES

PATIENTS TREATMENT DECISION:
_____ DOCUMENTATION OF DENTAL RECORD COMPLETED
_____ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ATLTERNATIVES DISCUSSED)
_____ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

LAB: _____ N_20 _____
MODELS:_____ MOST N.B. _____
PHOTOS 1._____ INSUR._____
2. _____ BP + DATE _____

SHADE

TOOTH	UPPER	LOWER
ANT.		
POST.		
ANT		
POST.		

EXISTING PROSTHESIS:
MAX._____ DATE PLACED: _____ CONDITION: _____
MAND._____ DATE PLACED: _____ CONIDTION: _____

NOTES:

Informed Consent

The undersigned hereby authorizes the Cosmetic Dental Rehab PC and Cosmetic Dental of Greenwich, P.L.L.C. to take X-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. Photographs may be used for educational purposes or publications. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk, including possible deficits or damage to nerve tissues and/or blood vessels. I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. Insurance coverage will be credited to my account, or refunded to me if I have fully paid the dental fees incurred. I authorize Cosmetic Dental NY and Greenwich,. to verify my past and present credit references. Cosmetic Dental NY and Greenwich are required by federal and state law to maintain the privacy of my health information, as per HIPPA regulations. I further agree that any dispute about the reasonableness or computation of fees, any claim of negligent or intentional acts and/or omissions in the rendering of professional services by any member of Cosmetic Dental NY and Greenwich, staff and/or our doctor, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration. I further understand that a finance charge will be added to any overdue balance.

Patient Signature (Parent of Child) _____ Date: _____

Cosmetic Dental Rehabilitation, P.C. **Cosmetic Dental of Greenwich, PLLC.**

Financial Policy

1. If you have any questions about fees for planned treatment, please ask us because it is your right to have any questions answered.
2. For routine dental work, payment is required on the day of service.
3. For crowns, bridges, implant tooth replacement and all porcelain restorations, unless another payment has been arranged in advance, half of the fee is expected prior to the first visit. The remaining half is due the day final impressions are taken. We accept cash, checks, and major bankcards (**MasterCard, Visa, American Express, and Discover.)**
4. Payment options: Our office offers the following additional choices for your convenience:
   - 5% savings for any fee (other than the initial consultation) paid in full at the time the appointment is scheduled for initiation of treatment.
   - Up to 12 months interest - free financing or up to 60 months low interest financing with rates based on length of contract utilizing **Citi Health or Care Credit** (limitations may apply).
5. Dental Insurance: We will gladly file your insurance so that you will receive maximum reimbursement if you provide: a completed insurance form for each patient, signed by the insured employee.

All dental fees are the direct responsibility of the patient.

Any outstanding balance not covered by one of these options will be billed and be subject to 1.5 % monthly service charge. All other questions concerning fees, balances and accounts may be answered in the expanded OFFICE FINANCIAL POLICY statement.

Appointments

Your appointment time has been reserved just for you. If you cannot keep your appointment, we ask you to give us 48 hours notice so that we may be able to fill your time slot. Otherwise, our office policy is to charge an hourly rate that covers our overhead. Exceptions are occasionally made, but are less likely if no or short notice is given or if appointments are broken frequently or regularly.

Privacy Notice

The privacy of your health and dental information is important to us. Under separate cover, you will receive a copy of our Notice of Privacy Practices under the HIPPA guidelines. This form describes how your health information may be used and disclosed and how you can get access to this information.

Photography

Dr. Doundoulakis often takes photographs to better explain certain aspects of your existing dental health or planned treatment to you. We request your permission to show these photographs to better explain treatment options to other patients (as you will be shown photos for the same reason.) And since he has a reputation as an expert in Cosmetic Dentistry, he also makes presentations to other dentist where the slides are invaluable in explaining the latest techniques and show the results that can be achieved when done precisely.

My signature acknowledges that:

The questions have been answered truthfully and completely,
I read, questioned, and then signed the Treatment Consent Form.
Photographs of me may be used for educational purposes as stated above.
I understand the office policy with keeping appointments.
I have read and signed the **Office Notice of Privacy Practices,** and
I understand and will comply with the office Financial Policy and Privacy Practices.

_____ _____

Patients Signature (or Parent if a minor) Date

Thank you for giving us the opportunity to help you achieve your dental goals. Our staff will strive to deliver the type of service and atmosphere that you should expect from a superb dental office. We value your opinion and appreciate hearing about the things you like and about the things we could improve to better serve you.

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We would like to thank you for scheduling a consultation visit with us today!

You are here to meet the doctor discuss any future dental treatment options you may be interested in pursuing. You have made an appointment to consult or investigate a second opinion with Dr. Doundoulakis. **This is not considered an exam and the consultation fee does not include any x-rays that may be needed.** All consultation fees are **non-refundable**. If you proceed with treatment in this office, a full exam, radiographs and possibly referred to another specialist will be required to confirm possible treatment options.

In our practice, the time of your appointment was reserved especially for you with our experienced office staff at your disposal. Our mission is to maintain the highest quality and standards of care.

_____ _____
Signature Date

_____
Print Name

WWW.COSMETICDENTALNY.COM

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We would like to point out that it is required that we receive notice of at least 48 hours (excluding Saturday and Sunday) from the time of their appointment from every patient regarding a change in their plans that causes them to reschedule this appointment. This gives our staff the opportunity to schedule another appointment during that time slot. Without this mandatory 48 hour notification, which does not include the weekends, we do find it necessary to charge a **$60.00 cancellation fee** per ½ hour of scheduled time.

In a dental practice when a patient does not keep a scheduled appointment, the doctor and the staff have lost that time forever. As a result, another patient who was in need of care was deprived of being treated by the doctor. In our practice, the time of your appointment was reserved especially for you with our office staff at your disposal.

I am sure you understand that we have such policies because our mission is to maintain the highest quality standards and offer our patients the best dental care, treatment, and service there is.

_____ _____
Signature Date

_____
Print Name

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Office Notice of Privacy Practices

Purpose**:** This notice of Privacy Practices presents the information that the HIPPA Privacy Rules require us to give out to patients regarding our **privacy practices, as stated in the Cosmetic Dental Rehab. and Cosmetic Dental of Greenwich, office Privacy Policy.**

We are providing this Notice to each patient. After April 14, 2003, we must also have the Notice available at the office for the patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manor consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

We must make a good faith effort to obtain a written acknowledgement of receipt of this Notice from each individual with whom we have a direct treatment relationship and to whom we provided this Notice, except in emergency situations. The bottom of this Notice is a written acknowledgement that will be retained in the patient's medical record. We will keep the acknowledgement in the patient's medical record.

Section A: The Patient

Name:_____

Address:_____

Telephone:_____ Email:_____

Patient Number:_____ Social Security Number_____
(Optional)

Section B: Acknowledgment of Receipt of Privacy Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from **Cosmetic Dental Rehab, and Cosmetic Dental of Greenwich.**

Signature: _____ Date:_____
If a personal representative signs this authorization on behalf of the individual, complete this following:

Personal Representative's Name: _____

Relationship to Individual: _____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

Signature
I attest that the above information is correct.
Signature: _____ Date:_____

Print name: _____ Title: _____