MAIN LINE
DENTAL CLUB

BOTOX onabotulinumtoxinA injection   Juvéderm   invisalign®

Smile/Facial Assessment

Please take your time and answer each question as clearly and accurately as you can. Your answers will help us determine the type of treatment most suited to your needs.

- Are you pleased with the general appearance of your teeth and smile? ○ YES ○ NO
  IF NO, LET US KNOW YOUR PRIMARY CONCERN:

- Are there any gaps in your teeth that you dislike or bother you, including missing teeth? ○ YES ○ NO
  IF YES, LET US KNOW WHERE (TOP OR BOTTOM JAW, LEFT OR RIGHT SIDE), AND HOW IT AFFECTS YOUR SMILE OR CHEWING:

- Do you have any old crowns that are discolored or look unnatural? ○ YES ○ NO
  IF YES, LET US KNOW WHERE (TOP OR BOTTOM JAW, LEFT OR RIGHT SIDE), AND HOW IT AFFECTS YOUR SMILE OR CHEWING:

- Would you like whiter teeth? ○ YES ○ NO
  IF YES, LET US KNOW IF YOU HAD ANY WHITENING PROCEDURES IN THE PAST, WHAT TYPE?

- Are your teeth straight? ○ YES ○ NO
  IF NO, LET US KNOW YOUR PRIMARY AREAS OF CONCERN:

- Have you ever had facial aesthetics treatment (Botox, Juvederm, etc.) before? ○ YES ○ NO
  IF YES, WHICH ONE(S), WHERE ON YOUR FACE AND WHEN?

- Would you be interested in learning more about facial aesthetics procedures? ○ YES ○ NO
  IF YES, WHICH PROCEDURE(S)?

- Is there anything else you would like to discuss with us regarding facial aesthetics treatment or the function and appearance of your teeth? ○ YES ○ NO
  IF YES, PLEASE EXPLAIN BELOW:

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Dental History

Patient Name ______________________________ (FIRST) (LAST) Birthdate ____ / ____ / ____ (MONTH / DAY / YEAR)

Address ____________ (STREET) ____________ (CITY) ______ (STATE) ______ (ZIP)

Phone (______)____________ Email ______________________

Marital Status ◯ MARRIED ◯ DIVORCED ◯ SINGLE Referred by ______________________

Previous Dentist ______________________ How long were you a patient? ______ ◯ MONTHS ◯ YEARS

Date of most recent dental exam ____ / ____ / ____ (MONTH / DAY / YEAR) Date of most recent x-rays ____ / ____ / ____ (MONTH / DAY / YEAR)

Date of most recent treatment (other than a cleaning) ____ / ____ / ____ (MONTH / DAY / YEAR)

How would you rate the condition of your mouth? ◯ EXCELLENT ◯ GOOD ◯ FAIR ◯ POOR

I routinely see my dentist every ◯ 3 MO. ◯ 4 MO. ◯ 6 MO. ◯ 12 MO. ◯ NOT ROUTINELY

What is your immediate concern? ____

____

Please answer yes or no to the following:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? If yes, how fearful, on a scale of 1 (least) to 10 (most) ______	◯	◯
2. Have you had an unfavorable dental experience?	◯	◯
3. Have you ever had complications from past dental treatment?	◯	◯
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	◯	◯
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	◯	◯
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	◯	◯

GUM AND BONE	YES	NO
7. Do your gums bleed or are they painful when brushing or flossing?	◯	◯
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	◯	◯
9. Have you ever noticed an unpleasant taste or odor in your mouth?	◯	◯
10. Is there anyone with a history of periodontal disease in your family?	◯	◯
11. Have you ever experienced gum recession?	◯	◯
12. Have you had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	◯	◯
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	◯	◯

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Dental History

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	○	○
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	○	○
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	○	○
18. Do you have grooves or notches on your teeth near the gum line?	○	○
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	○	○
20. Do you frequently get food caught between any teeth?	○	○

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	○	○
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	○	○
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry food?	○	○
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	○	○
25. Are your teeth becoming more crooked, crowded, or overlapped?	○	○
26. Are your teeth developing spaces or becoming more loose?	○	○
27. Do you have trouble finding your bite or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	○	○
28. Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
30. Do you clench or grind your teeth together in the daytime or make them sore?	○	○
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	○	○
32. Do you wear or have you ever worn a bite appliance?	○	○

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	○	○
34. Have you ever whitened (bleached) your teeth?	○	○
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	○	○
36. Have you been disappointed with the appearance of previous dental work?	○	○

Patient's Signature ______________________________ Date ______ / ______ / ______
MONTH DAY YEAR

Doctor's Signature ______________________________ Date ______ / ______ / ______
MONTH DAY YEAR

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Medical History

Patient Name ______________________________ (FIRST / LAST) Age __________

Name of Physician ____________________ Specialty, if applicable ____________________

Most recent physical examination ______ / ______ / ______ (MONTH / DAY / YEAR) Purpose ____________________

What is your estimate of your general health? ○ EXCELLENT ○ GOOD ○ FAIR ○ POOR

DO YOU HAVE OR HAVE YOU EVER HAD: (If yes, explain any details in space provided)	YES	NO
1. Hospitalization for illness or injury ______	○	○
2. An allergic or bad reaction to any of the following:		
Aspirin, ibuprofen, acetaminophen, codeine ______	○	○
Penicillin ______	○	○
Erythromycin ______	○	○
Tetracycline ______	○	○
Sulfa ______	○	○
Local anesthetic ______	○	○
Uoride ______	○	○
Chlorhexidine (CHX) ______	○	○
Metals (nickel, gold, silver) ______	○	○
Latex ______	○	○
Nuts ______	○	○
Fruit ______	○	○
Other ______	○	○
3. Heart problems, or cardiac stent in the last 6 mos. ______	○	○
4. History of infective endocarditis ______	○	○
5. Pacemaker or implantable debrillator ______	○	○
6. Articial heart valve, repaired heart defect (PFO) ______	○	○
7. Orthopedic implant (joint replacement) ______	○	○
8. Rheumatic or scarlet fever ______	○	○
9. Highor low blood pressure ______	○	○
10. A stroke (taking blood thinners) ______	○	○
11. Anemia or other blood disorder ______	○	○
12. Prolonged bleeding due to a slight cut (INR>3.5) ______	○	○
13. Pneumonia, emphysema, shortness of breath, sarcoidosis ______	○	○
14. Chronic ear infections, tuberculosis, measles, chicken pox ______	○	○
15. Asthma ______	○	○
16. Breathing or sleep problems (e.g., sleep apnea, snoring, sinus) ______	○	○
17. Kidney disease ______	○	○
18. Liver disease ______	○	○
19. Jaundice ______	○	○
20. Thyroid, parathyroid disease, or calcium deciency ______	○	○
21. Hormone deciency ______	○	○
22. High cholesterol or taking statin drugs ______	○	○
23. Diabetes (HbA1c=________)	○	○
24. Stomach or duodenal ulcer ______	○	○
25. Digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______	○	○

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Medical History

DO YOU HAVE OR HAVE YOU EVER HAD: (If yes, explain any details in space provided)	YES	NO
26. Osteoporosis, osteopenia (e.g., taking bisphosphonates) ______	○	○
27. Arthritis ______	○	○
28. Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ______	○	○
29. Glaucoma ______	○	○
30. Contact lenses ______	○	○
31. Head or neck injuries ______	○	○
32. Epilepsy, convulsions (seizures) ______	○	○
33. Neurologic disorders (ADD/ADHD. prion disease) ______	○	○
34. Viral infections and cold sores ______	○	○
35. Any lumps or swelling in the mouth ______	○	○
36. Hives, skin rash, hay fever ______	○	○
37. STI/STD/HPV ______	○	○
38. Hepatitis (type______)	○	○
39. HIV/AIDS ______	○	○
40 Tumor, abnormal growth ______	○	○
41. Radiation therapy ______	○	○
42. Chemotherapy, immunosuppressive medication ______	○	○
43. Emotional diculties ______	○	○
44. Psychiatric treatment ______	○	○
45. Antidepressant medication ______	○	○
46. Alchohol/recreational drug use ______	○	○

ARE YOU: (If yes, explain any details in space provided)	YES	NO
47. Presently being treated for any other illness ______	○	○
48. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ______	○	○
49. Taking medication for weight management ______	○	○
50. Taking dietary supplements ______	○	○
51. Often exhausted or fatigued ______	○	○
52. Experiencing frequent headaches ______	○	○
53. A smoker, smoked previously or use smokeless tobacco ______	○	○
54. Considered a touchy/ sensitive person ______	○	○
55. Often unhappy or depressed ______	○	○
56. Taking birth control pills ______	○	○
57. Currently pregnant ______	○	○
58. Diagnosed with a prostate disorder ______	○	○

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) ______

______

List all medications, supplements, and or vitamins taken within the last two years. ______

______

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______ Date ____ / ____ / ____
MONTH DAY YEAR

Doctor's Signature ______ Date ____ / ____ / ____
MONTH DAY YEAR

10 W. Lancaster Ave, Paoli PA 19301 PHONE 610.644.5547 FAX 610.644.1081 EMAIL Akpo@Dentify.com

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Financial Responsibility

I, ____,
FIRST NAME LAST NAME

with SS#: ________—________—___________, understand that I am financially responsible for all charges for services rendered by **Dr. Gulia Omene / Main Line Dental Club** with payment due on the day of service.

I have read and understand the above.

________________________________ or ________________________________
Signature of Patient Signature of Responsible Party

____
Relationship to Patient:

Date ______ / ______ / ______
MONTH DAY YEAR

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HIPAA Authorization

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING, PUBLIC RELATIONS AND EXTERNAL COMMUNICATIONS.

I hereby authorize Gulia Omene DMD LLC, d/b/a Main Line Dental Club , and its owners, employees, affiliates, licensees and assigns (collectively, "Main Line Dental Club ") to use, disclose and release my Health Information, as defined below, for the purposes set forth in this Authorization.
By initialing below, I specifically authorize Main Line Dental Club to use, disclose and release the following "Health Information" about me:

__________ (initial) My appearance, image, name, diagnosis and medical/dental condition; pictures, images and video relating to the treatments and services that I receive and the results of such treatments and services; and related medical and dental records.

__________ (initial) The following information: ____
____
____

The Health Information, initialed above, may be used for promotional, advertising, marketing, educational and informational purposes, which is intended by Main Line Dental Club to generate additional business for its dental practice,through local, state and national media broadcasting and publication outlets, including, without limitation, any and all websites, portfolios, catalogs, training materials, advertisements, brochures, photographs, posters, videos,commercials, displays, newsletters, news or editorial coverage or any other media now or hereafter known or devised, with and without my name, both singly and in conjunction with other persons.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time ("HIPAA"). I understand that I have the right to revoke this Authorization, but such revocation shall not apply to the extent that Main Line Dental Club has already relied on this Authorization. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in Main Line Dental Club's Notice of Privacy Practices. I understand that any revocation must be in writing and include my name,address, telephone number, date of this Authorization and my signature, and that I must send it to: Gulia Omene DMD LLC, d/b/a Main Line Dental Club, 10 W. Lancaster Ave, Paoli PA 19301, Paoli, PA 19301; Attn: Privacy Officer.

I understand that I am not required to sign this Authorization as a condition for me to receive treatment from or with Main Line Dental Club,. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure once it is used for the intended purpose and, in that case, will no longer be protected by HIPAA. This Authorization shall expire after one year following the date of its execution. I hereby acknowledge receipt of a copy of this Authorization.

____
Signature of Individual (or Legal Representative)

____
Legal Rep's Authority

____
Print Name of Individual (patient)

Date ______ / ______ / ______
MONTH DAY YEAR

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Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

_______________________________________ _______________________

Signature of Individual (or Legal Representative) Legal Rep's Authority

_______________________________________ Date ______ / ______ / ______ (MONTH DAY YEAR)

Print Name of Individual (patient)

Electronic Notice: If you would like to receive updates or changes to the Notice **electronically**, please provide your personal email address: _______________________________________

You will also be able to receive paper copies of the current Notice upon request.

If signed by a Personal Representative:

_______________________________________ _______________________

Print Name Relationship to Patient (parent, guardian, etc.)

OFFICE USE ONLY

If the Patient has a Personal Representative with legal authority to make health care decisions on the Patient's behalf, the Notice must be given to, and acknowledgment obtained from, the Personal Representative. **If the Patient or Personal Representative did not sign above, document when and how the Notice was given to the Patient or Personal Representative and why the signed acknowledgment could not be obtained.**

- **Notice of Privacy Practices given to the individual on ______ / ______ / ______ (MONTH DAY YEAR) by:**
  - ◯ FACE TO FACE MEETING
  - ◯ MAILING
  - ◯ EMAIL
  - ◯ OTHER: _______________________________________
- **Reason Individual or Personal Representative did not sign this form:**
  - ◯ PATIENT OR PERSONAL REPRESENTATIVE CHOSE NOT TO SIGN
  - ◯ PATIENT OR PERSONAL REPRESENTATIVE DID NOT RESPOND AFTER MORE THAN **ONE** ATTEMPT
  - ◯ EMAIL RECEIPT VERIFICATION
  - ◯ OTHER: _______________________________________

Good Faith Efforts: The following good faith efforts were made to obtain the Patient's signature or, if applicable, the signature of such Patient's Personal Representative. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the Patient's signature or, if applicable, the signature of such Patient's Personal Representative.

Face-to-face presentation(s): _______________________________________

Telephone contact(s): _______________________________________

Mailing(s): _______________________________________

Email attempts _______________________________________