Dr. Reya C. Weeks
Family Dentistry
2200 Winter Springs Blvd Suite 103 Oviedo, FL 32765 407/365-9772

Greetings from the hygiene department! This letter is just to give you an idea of what to expect during your initial visit with us. You will have oral x-rays taken of all your teeth, we will perform a cleaning, and the doctor will do a comprehensive examination of teeth and gums. Before we start your cleaning, we will evaluate and consult with you first on what type of cleaning you will get. This is determined by us examining your gums. In our office, dental cleanings come in three types:

1) **Standard Adult Prophy**, generally referred to as *regular cleaning*, and is often covered by insurance at a hundred percent (your specific insurance plan will determine this). This type of cleaning is done if you have generally healthy gums – no bleeding, pink gums, and minimal plaque (soft build-ups around your teeth and gums).
2) **Full Mouth Debridement**, sometimes referred to as *gross debridement,* and most insurances cover this at 80% (but again, your specific insurance plan will determine this). This type of cleaning is done if you have mild to moderate calculus build-up (tartar, hard deposits around your teeth and gums). Should you need this type of cleaning on your first initial visit, sometimes we re-appoint you to come back for a *fine scale*. Basically fine scale is to remove any left over spicules of tartar as well as polish your teeth. We evaluate how well your gums responded to the full mouth debridement. If your gums do not heal well, it may be necessary to have to do another debridement or do a *deep cleaning.* This type is often performed to prevent advanced stages of gum (periodontal) disease; which may necessitate visiting a specialist (Periodontist/gum specialist).
3) **Scaling & Root Planing,** this cleaning is generally referred to as *deep cleaning or quads.* Insurance coverage for this type varies with different insurances. Scaling and root planning (deep cleaning) is not generally performed on initial visits. The doctor will determine if you need this deep cleaning after viewing your x-rays and performing a periodontal examination. Full mouth debridement is performed on initial visits to remove the bulk of the tartar build-up out and allows for better examination, you will then be reappointed at a later date to have the scaling and root planning done.
   Scaling is removing the calculus deposits from your teeth. Root planing is the smoothing of the root surfaces so that the gum tissue can reattach to the tooth. The preceding 3 types of cleanings are performed in our dental office. Should you have advanced gum (periodontal) disease, you will be referred to a Periodontist. Periodontal disease is the single most common cause of tooth loss in adults. This inflammatory disease attacks the gums, bone, and other supporting structures of the teeth.

Each of us is different, and so is our individual ability to resist diseases. Some patients are more susceptible than others to periodontal disease. Fortunately, you don't have to lose your teeth to gum disease. With today's state-of-the-art treatment procedures, you can feel assured that most teeth can be saved.

With look forward to seeing you!

The Hygiene Department

2200 Winter Springs Blvd Ste 103 Oviedo, FL 32765 (407) 365-9772

PATIENT INFORMATION

Last name: _____ First name: _____ Middle Initial: ___

Nickname: _____ Male: ___ Female: ___ DOB: _____ SSN: _____

Marital Status: ___Single ___ Married ___ Separated ___ Divorced ___ Widowed

If patient is under 18 years old, Parent/Guardian's Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email Address: _____

Which way would be best to contact you? Home phone: ___ Cell: ___ Work: ___ E-mail: ___

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship to patient: _____

INSURANCE INFORMATION

Employer: _____

Insurance Company Name: _____ Phone: _____

Policy/Member Number: _____ Group Number: _____

Name of Insured: _____ SSN: _____

Insured's Date of Birth: _____ Patient's Relationship to Insured: _____

RESPONSIBLE PARTY

Self: ___ Other: ___ If other, please complete:

Name: _____ Phone: _____

Address: _____

City: _____ ST: _____ Zip: _____

SSN: _____ Date of Birth: _____ Relationship to Patient: _____

I certify and that my responses are true and correct to the best of my knowledge and will notify this office should any of the above information change.

_____ _____

Signature Date

ADA American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: Home Phone: ( ) Business Phone: ( )
LAST FIRST MIDDLE

Address: City: State: Zip Code:
P.O. BOX or Mailing Address

Occupation: Height: Weight: Date of Birth: Sex: M ❑ F ❑

SS#: Emergency Contact: Relationship: Phone: ( )

If you are completing this form for another person, what is your relationship to that person?
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑	❑

If yes, explain:

How would you describe your current dental problem?

Date of your last dental exam:

Date of last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated?

Date of last physical examination:

Physician:
NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem?

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparations and/or diet supplements:

	Yes	No	Don't Know
Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours?

In the past week?

Are you alcohol and/or drug dependent?	❑	❑	❑

If yes, have you received treatment? (circle one) Yes / No

Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list:

Frequency of use (daily, weekly, etc.):

Number of years of recreational drug use:

Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

Do you wear contact lenses?	❑	❑	❑

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food (specify) _____	❑	❑	❑
Other (specify) _____	❑	❑	❑
Metals (specify) _____	❑	❑	❑

To yes responses, specify type of reaction.

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑	❑

If yes, when was this operation done?

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑	❑

If yes, what antibiotic and dose?

Name of physician or dentist*:

Phone:

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion. If yes, date: _____	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑

____ Angina
____ Arteriosclerosis
____ Artificial heart valves
____ Congenital heart defects
____ Congestive heart failure
____ Coronary artery disease
____ Damaged heart valves
____ Heart attack
____Heart murmur
____High blood pressure
____Low blood pressure
____Mitral valve prolapse
____Pacemaker
____Rheumatic heart disease/Rheumatic fever

Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Disease, drug, or radiation-induced immunosurpression	❑	❑	❑
Diabetes. If yes, specify below:	❑	❑	❑

____ Type I (Insulin dependent) ____Type II

Dry Mouth	❑	❑	❑
Eating disorder. If yes, specify: _____	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/persistent heartburn	❑	❑	❑
Glaucoma	❑	❑	❑

	Yes	No	Don't Know
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent Infections	❑	❑	❑

If yes, indicate type of infection: _____

Kidney problems	❑	❑	❑
Mental health disorders. If yes, specify: _____	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders. If yes, specify: _____	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	❑	❑	❑

____ Emphysema ____ Bronchitis, etc.

Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑

	Yes	No	Don't Know
Do you have any disease, condition, or problem not listed above that you think I should know about?	❑	❑	❑

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

PATIENT CONSENT FORM

The undersigned hereby authorizes Doctor (Dr. Reya Weeks) and her staff to take radiographs, study models, photographs, or any other diagnostic tools, all deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. The undersigned also authorizes Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Patient) _____. And further authorize and consent that Doctor choose and employ such assistance as she deemed fit. Patient understands that use of anesthetic agents embodies a certain risk.

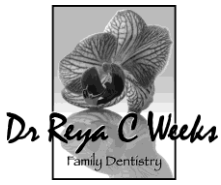
I, the patient/guardian, understand that dentistry is not an exact science and that specific results cannot be assured or guaranteed. I understand that during treatment, it may be necessary to change or add procedures because of conditions discovered during the treatment that were not evident during examination. I understand and authorizes the Doctor to used her best professional judgment to provide the appropriate care even when this represents a change in the diagnosed problem and course of treatment. I acknowledge that no such guarantees have been made regarding the dental treatment to be performed. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

I truthfully revealed all aspects of my health history and I realize that failure to have done so may have negative consequences for my health and the success of my treatment. I agree to cooperate fully with the recommendations of my Dentist and Dental Hygienist and I realize that failure to do so may result in less than optimum results and compromise the life span of my treatment. I also agree to follow the recommendations for home care and the schedule for future tooth cleaning and check-ups. I realized that failure to do my part in the maintenance of my oral health will compromise the success of any dental treatment I may receive.

CONSENT: I certify that I understand fully, all the statements mentioned above.

_____ _____

Patient / Guardian Today's Date



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FINANCIAL INFORMATION

PATIENTS WITH DENTAL INSURANCE

As courtesy to you, our patients, we will bill your insurance company and take assignment of benefits.

You are immediately responsible for the deductible and your portion of the treatment charges not covered by your dental insurance at the time of treatment.

If payment is not received from your insurance carrier in a timely manner, you are responsible for the total balance.

There is a finance charge of 1.5% per month, which is 18% per year assessed on all balances over 30 days past due.

We guarantee our services and products so long as you or other provider/dentist does not alter the treatment/product; and applicable hygiene appointments are maintained with our hygiene department.

I, _____, the patient, have read, and understood the statements mentioned above. If for any reasons there are collection fees, court or attorney costs are incurred to collect any balance due, I understand that I am personally responsible for paying them in full.

_____ _____

Signature Date

Smile Assessment Form

Please consider each statement carefully and circle YES or NO. The doctors and members of the dental team will discuss your responses with you in confidence.

1.	I am concerned about the appearance of my teeth or my smile.	YES NO
2.	I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES NO
3.	I am concerned about the position or angle of one or more of my teeth.	YES NO
4.	I am concerned about the shape of one or more of my teeth.	YES NO
5.	In social situations, I am sometimes embarrassed by my teeth or my smile.	YES NO
6.	There are some things about my upper front teeth that I would like to change.	YES NO
7.	There are some things about my lower front teeth that I would like to change.	YES NO
8.	I have old fillings or previous dental treatment that is no longer satisfactory to me.	YES NO
9.	I am missing one or more of my teeth.	YES NO
10.	I am interested in learning more about esthetic dentistry.	YES NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concern so that we can present you with the best possible treatment options. Thank you.