



We understand that for many, an undesirable smile significantly influences self-confidence. It is our mission is to deliver life changing smile enhancements in a pleasant and relaxing environment. With an unfailing dedication to scientific advances, technological developments, and superior skills, we are able to provide our patients with the finest cosmetic dentistry possible available. For this, our services have been internationally recognized.

Our approach to restoring confident smiles is always as conservative and non-invasive as possible. To deliver the ideal smile makeover, we take into consideration a clients unique facial form including their bone structure, skin and eye color, contour and shape of the lips, the gum shape and position, and of course, the teeth and how they all interrelate.

When we bring this all together, the results will have an affirmative impact on the overall appearance and self confidence of the client. The outcome is always natural and extraordinary. We welcome you to our practice.

**Patient Information:**

Patient's Name: MR/MRS/MS/DR (Last) \_\_\_\_\_ (MI) \_\_\_\_\_ (First) \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number (For your Insurance Reimbursement) \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
BusinessAddress: \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Business Number: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
Mobile: (\_\_\_\_) \_\_\_\_\_ Pager:(\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
How did you learn about us? \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_

**Emergency Contact Information:**

Name: (Last) \_\_\_\_\_ (MI) \_\_\_\_\_ (First) \_\_\_\_\_  
Daytime Number: (\_\_\_\_) \_\_\_\_\_ Evening Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship: \_\_\_\_\_

**Responsible Party's Information: (Only to be completed if the patient is under 18)**

Responsible Party's Name (Last) \_\_\_\_\_ (MI) \_\_\_\_\_ (First) \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security Number \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
BusinessAddress: \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Business Number: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
Mobile: (\_\_\_\_) \_\_\_\_\_ Pager:(\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_



**Payment Arrangement Procedures**

All fees are due and payable in full one week prior to your reserved appointment time (unless prior arrangements have been made). If the appointment time is reserved within or under a week, the full fee is due immediately upon that reservation.

**Scheduling Procedures**

Please understand that any time appointed to you is reserved exclusively for you. It is part of our mission to provide our clientele with the highest-quality service available. For this reason, a minimum of two business day’s notice is necessary to make any changes to reserved time for short visits. For changes to be made on reserved time for an hour or more, a minimum of one-week’s notice is required. Any matter concerning reserved time is to be handled by the front desk during our business hours, Monday-Thursday. For any changes in scheduling made without the above said notice, a fee of \$100 per half-hour of reserved time will be forfeited from any account credit, or will be charged to your account. For any changes in scheduling made without the above said notice, for services of \$1,000 or more, ¼ of the full fee will be forfeited from any account credit, or will be charged to your account.

Due to clinical situations, a proposed treatment plan may require changes. The client will be informed of any changes in treatment as they occur, and of any changes in the client’s/responsible party’s financial responsibility. The client/responsible party is liable for the fees associated with these changes.

All estimated treatment fees are guaranteed until the expiration date listed on the treatment plan.

I have read and understand all that is explained above and agree to abide by all of NYC Smile Design’s guidelines.

X Patient (Guardian’s) Signature \_\_\_\_\_ Date \_\_\_\_\_

**Continue Below *Only* If You Have Dental Benefits**

Our practice is committed to offering the most superior treatment and services available. We believe you deserve the best care. We will always present you with the best dental solution possible to treat your personal situation.

Each year we provide outstanding care to hundreds of people. Some have dental benefits, but most don’t. If you have dental benefits, congratulations! You are very fortunate.

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.

You should know Insurance companies do not recognize many routine and newer dental services. Dental benefits will never pay for the completion of your dental care. It is only meant to assist you.

As part of our commitment to providing you with excellent service, we will do our best to help coordinate your dental benefits so that you receive the maximum possible reimbursement for the services we have provided you.

As a courtesy, our staff will gladly provide you with any necessary forms or submit any paperwork on your behalf to assist you in receiving direct reimbursement by your insurance carrier.

If you have dental benefits, and would like us to assist you in receiving disbursement from them, please provide us with the following information:

**Policy Member’s Info:**

Name (Last) \_\_\_\_\_ (MI) \_\_\_\_\_ (First) \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Business Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please Circle: Social Security# or Member ID# \_\_\_\_\_ Group/Policy# \_\_\_\_\_

**Insurance Company’s Info:**

Insurance Company Name \_\_\_\_\_

Dental Claim Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize NYC Smile Design, office of Dr. Ramin Tabib and Dr. Elisa Mello to provide the above insurance company’s claim administrators and consulting healthcare professional’s information and diagnostic records concerning treatment provided and recommended to me. I understand that this information will be used for the purpose of evaluating and administrating claims for my reimbursement (it is likely that payment will be sent to the address on file with the member’s policy). To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

X Patient (Guardian’s) Signature \_\_\_\_\_ Date \_\_\_\_\_



# NYC SMILE DESIGN

## Patient's Name

(Last) \_\_\_\_\_ (MI) \_\_\_\_\_ (First) \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Dental History

What is your immediate dental concern? \_\_\_\_\_

How can we help you? \_\_\_\_\_

What are your particular expectations for today's visit? \_\_\_\_\_

What are you long term dental goals? \_\_\_\_\_

General Dentist \_\_\_\_\_ How long? \_\_\_\_\_

What do you like best about your general dentist? \_\_\_\_\_

Have you been satisfied with your previous dentistry?  Yes  No

Have you had any bad experiences? Elaborate \_\_\_\_\_

Most recent dental exam? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Most recent dental treatment? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Most recent dental x-rays? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

How often do you have your teeth cleaned?  3 months  4 months  6 months  12 months  longer \_\_\_\_\_

Who determined that schedule? \_\_\_\_\_

What has dentistry been like for you? \_\_\_\_\_

How would you describe your current dental health? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

## Please answer Yes or No to the following and provide any additional information in the explain section

Yes  No Do you have any particular dental fears? Explain \_\_\_\_\_

Yes  No Problems with effectiveness or bad reaction to dental anesthetic? \_\_\_\_\_

Yes  No Orthodontic treatment? (Braces) When \_\_\_\_\_ What type? \_\_\_\_\_ How long? \_\_\_\_\_

Yes  No Periodontal treatment? (Gum) When \_\_\_\_\_

Yes  No Bleeding Gums? Explain \_\_\_\_\_

Yes  No Part of your mouth sensitive to temperature? Explain \_\_\_\_\_

Yes  No Sore teeth? Where? Explain \_\_\_\_\_

Yes  No Burning sensation in your mouth? Explain \_\_\_\_\_

Yes  No Difficulty swallowing? Explain \_\_\_\_\_

Yes  No Unpleasant odor or taste in your mouth? Explain \_\_\_\_\_

Yes  No Dry mouth, throat or eyes? Explain \_\_\_\_\_

Yes  No Jaw problems (TMJ/Temporomandibular joint)? Explain \_\_\_\_\_

Yes  No Do you wear or have you ever worn a nightguard or occlusal appliance?

Yes  No Difficulty in opening your mouth widely? Explain \_\_\_\_\_

Yes  No Stiff neck muscles? Explain \_\_\_\_\_

Yes  No Awaken with an awareness of your teeth or jaws?

Yes  No Tension headaches? How frequent? \_\_\_\_\_

Yes  No Clench or grind your teeth? When? Explain \_\_\_\_\_

Yes  No Jaw clicking or popping? Explain \_\_\_\_\_

Yes  No Lost any teeth? Explain \_\_\_\_\_

Yes  No Are you wearing replacements? For how long? Explain \_\_\_\_\_

Yes  No Do you experience anxiety at the dental office? Explain \_\_\_\_\_

Yes  No Have you ever had a dental emergency? Explain \_\_\_\_\_

Any additional comments: \_\_\_\_\_



# NYC SMILE DESIGN

Please select an answer for each of the following.

Are you allergic to any of the following?

- Yes  No Aspirin
- Yes  No Ibuprofen
- Yes  No Acetaminophen
- Yes  No Penicillin/Amoxicillin
- Yes  No Erythromycin
- Yes  No Tetracycline
- Yes  No Codeine
- Yes  No Local Anesthetics
- Yes  No Fluoride
- Yes  No Metals (gold stainless steel, \_\_\_\_\_)
- Yes  No Latex
- Yes  No Any other medication \_\_\_\_\_

Yes  No Are you required to take pre-medication before dental treatment? If yes, for what condition \_\_\_\_\_

Female:

- Yes  No Taking birth control
- Yes  No Pregnant

Male:

- Yes  No Prostate disorders

Name of Physician \_\_\_\_\_

Most recent Physical \_\_\_\_\_

List any medication, herbal supplements, and or vitamins taken within the last two years

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any of the following conditions?

- Yes  No Heart problems
- Yes  No Heart murmur
- Yes  No Rheumatic fever
- Yes  No High blood pressure
- Yes  No Low blood pressure
- Yes  No History of a stroke
- Yes  No Artificial prosthesis (i.e. heart valve or joints)
- Yes  No Anemia
- Yes  No Prolonged bleeding due to slight cut
- Yes  No Emphysema
- Yes  No Tuberculosis
- Yes  No Asthma
- Yes  No Sinus problems
- Yes  No Kidney disease
- Yes  No Liver disease
- Yes  No Jaundice
- Yes  No Thyroid or parathyroid disease
- Yes  No Arthritis
- Yes  No Glaucoma
- Yes  No Diabetes
- Yes  No Stomach or Duodenal ulcer
- Yes  No Digestive disorders
- Yes  No Epilepsy or convulsions (seizures)
- Yes  No Hepatitis (type \_\_\_\_\_)
- Yes  No HIV/AIDS
- Yes  No Radiation therapy
- Yes  No Chemotherapy
- Yes  No Tumor or abnormal growth
- Yes  No Any lumps or swelling in the mouth
- Yes  No Hives, skin rash, hay fever
- Yes  No Alcohol or Drug Dependency
- Yes  No Emotional Problems
- Yes  No Psychiatric treatment
- Yes  No Antidepressant medications
- Yes  No Often unhappy or depressed
- Yes  No Are you presently being treated for any illness?
- Yes  No Aware of changes in your general health
- Yes  No Often exhausted or fatigued
- Yes  No Subject to frequent headache
- Yes  No Heavy smoker (1 or more packs a day)
- Yes  No Head or neck injuries
- Yes  No Contact lenses

X Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_