CUSTOM ANALYZING YOUR OWN SMILE:

Your smile affects your self-image, and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile. Go to a mirror, smile as wide as you can, and ask yourself the following questions:

Are any of your teeth yellow, stained or somewhat discolored?	○ Yes	○ No
Would you like your teeth to be whiter?	○ Yes	○ No
Do you have any gaps or spaces between your teeth?	○ Yes	○ No
Are any of your teeth turned, crooked, or uneven?	○ Yes	○ No
Are you missing any teeth?	○ Yes	○ No
Do you see any pitting or defects on the surfaces of your teeth?	○ Yes	○ No
Are the edges of any teeth worn down, chipped or uneven?	○ Yes	○ No
Do any of your teeth appear too small, short, large or long?	○ Yes	○ No
Do you have any prior dental work that appears unnatural?	○ Yes	○ No
Do you have any crowns or bridges that appear dark at the edge of your gums?	○ Yes	○ No
Do you have any gray, black or silver (mercury) fillings in your teeth?	○ Yes	○ No
Do you have a "gummy" smile (too much of your gums show when smiling)?	○ Yes	○ No
Are your gums red, sore, puffy, bleeding or receded?	○ Yes	○ No
Does the appearance of your smile inhibit you from laughing or smiling?	○ Yes	○ No
When being photographed, do you smile with your lips closed instead of flashing a full smile?	○ Yes	○ No
Are you self-conscious about your teeth or smile?	○ Yes	○ No
Would you like to change anything about the appearance of your teeth or smile?	○ Yes	○ No

If you answered **YES** to **ANY** of the questions above, there are often several alternatives to improve your teeth and smile. To receive a personalized response to your smile analysis, please complete the form below.

You can have the smile you've always wanted! To schedule a **FREE, no obligation office consultation**, contact us today to schedule an appointment.

DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

ATLANTIC DENTAL HEALTHCARE, PA
Vaidya Selvan, BDS, DDS, MAGD, FICOI
28 Throckmorton Lane, Suite 201
Old Bridge, NJ 08857
(732) 679-8300

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ NoIf yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex _____
- ☐ Other _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Dr.Selvan's Office Policy

Welcome to our practice. To keep our office running efficiently, please:

- Call our office for an appointment 732-679-8300 or a request can be made on our website 24/7 www.DrSelvanDDS.com .
- You can e-mail us anytime : drrvselvan@gmail.com or leave a voicemail.
- The Patient registration form is on our website. You can print, complete then bring it with you. You can also complete the form in our office.
- Please be in our office 15 minutes prior to your appointment time with your photo ID and a current dental insurance card.
- Please provide us with your current: address, phone numbers, e-mail, insurance and medical history.
- All appointments are confirmed a week in advance. Cancellations must be made 48 hours prior to your appointment or a fee of $100. will be charged to your account. This payment must be made prior to rescheduling. If you arrive late for your appointment, you will have to wait until the scheduled patients are seen or re-schedule.

Dental Insurances:

- If you have a dental insurance policy, it is a contract between your employer and the insurance carrier.
- As a courtesy, we will file dental claims/ pre-treatment estimates on your behalf. Please note, it is your responsibility to follow through with your insurance carrier.
- On all return checks there will be a $50 charge plus all bank fees.
- THANK YOU FOR YOUR PATRONAGE.

Please sign, Patient/legal guardian _____

Please Print Name _____ Today's Date _____