DENTAL ARTS ON ESSEX

DR. MADELINE NIZIAK • DR. HANNAH NOYES

To Our New Patient,

Thank you for choosing Dental Arts on Essex (previously Hjorth Dental Group) and taking the time to read about our practice! We would like to take a moment to welcome you to our office by giving you a little knowledge on who we are and what we are all about. Our entire team is comprised of dedicated and experienced dental professionals, who collaboratively have over 45 years of experience. All our doctors and staff are committed to lifelong continuing education to best serve the needs of our patients. We are a family practice that utilizes a comprehensive approach to provide compassionate, high-quality care. We are confident that our office will meet and exceed all your expectations, as we have a state-of-the-art facility, comply with all OHSA regulations, and can do so in a very relaxing, fun, and warm environment. We strive to ensure you leave your first visit feeling welcomed and very informed.

For your first visit, you will have one-on-one reserved time with one of our doctors, Dr. Madeline Niziak or Dr. Hannah Noyes. Our initial examination appointment is used to obtain a complete dental history and clinical examination, along with necessary x-rays and photos. The more comprehensive our examination is, the more intelligently we can recommend the best dental care for you. Our ultimate goal is to help you preserve your teeth and become an active player in not just your oral health, but your overall health as well. If you have any specific concerns, we of course welcome any and all questions. We pride ourselves on providing a judgment-free atmosphere.

In order to be best prepared for your upcoming visit, please check with your previous dentist to find out if you have current x-rays. If you have dental insurance benefits, please provide us with your information prior to your visit, if possible. ***We have also taken this opportunity to enclose some forms for you to fill out and bring with you to your scheduled appointment.***

Please do not hesitate to call our office at any time to answer questions about the practice, our philosophy, and our services. If it is after business hours when you call, please feel free to leave a message with a convenient time to call you, as well as your name and phone number, and we will return your call.

We know there are many choices available when choosing your dentist and we sincerely appreciate you putting your trust in Dental Arts on Essex. We warmly welcome you to our practice and enjoy the opportunity of serving you. Thank you for calling our office and we look forward to meeting you at your first visit!

Warmest regards,

Drs. Niziak & Noyes and the entire team at Dental Arts on Essex

DENTAL ARTS ON ESSEX
DR. MADELINE NIZIAK • DR. HANNAH NOYES

New Patient Information

Welcome to our practice! We are so happy you're here.
Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We are excited to work with you to achieve & maintain a healthy, confident smile and total dental wellness.

Patient Information

Today's date _____

First name_____Middle initial_____Last name _____

I prefer to be called (nickname, etc.)_____ ☐ Male ☐ Female ☐ Nonbinary

Address_____City_____State_____ZIP_____

Date of birth_____Social security no. _____

Home phone (____) _____-_____Work phone (____) _____-_____Cell phone (____) _____-_____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Preferred method of contact ☐ Call ☐ Text ☐ E-mail

Fax (____) _____-_____E-mail_____Driver's license no. _____

Employer_____Occupation _____

How did you find us OR whom may we thank for referring you? _____

_____

Person to contact in case of emergency

Name_____Relationship _____Preferred method of contact ☐ Call ☐ Text ☐ E-mail

Phone (cell/home/work) _____ Email _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam_____Date of last cleaning_____Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City_____State_____Phone (____) _____-_____

Why are you changing dentists? _____

How often do you have dental examinations?_____How often do you brush your teeth? _____

How often do you floss?_____What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No

New Patient Information

Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

ARE YOU CURRENTLY TAKING ANY MEDICATIONS/DRUGS? (including over-the-counter medicines, aspirin, etc.) ☐ Yes ☐ No

If YES, please LIST: _____

Have you ever taken bisphosphonates or other osteoporosis/osteopenia medications? ☐ Yes ☐ No

If so, how long ago? _____

Have you ever been or are you currently required to take *PRE-MEDICATION* antibiotics before dental visits? ☐ Yes ☐ No

If so, for what reason? _____

Do you use tobacco? ☐ Yes ☐ No **Do you use alcohol, marijuana, or any other controlled substance?** ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No			

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric/		
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No
Artificial Bones/Joints	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart (Surgery, Disease,			Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Attack)	☐ Yes	☐ No	Shingles/Chicken Pox	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Sickle Cell Disease/Traits	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Hemophilia/Abnormal			Snoring/Sleep Apnea	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Stomach Problems/ Ulcers	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Diabetes Type I / II (circle)	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease/STD	☐ Yes	☐ No

Please list any serious medical condition(s) that you have ever had not listed above:

_____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other _____		

Patient signature _____

Dental Insurance

Primary Carrier

Insurance co. name_____ Insurance co. phone _____
Address (Street, City, State, ZIP) _____
Group no. (Plan or Policy no.)_____ Insured's I.D. no. _____
Insured's name_____ Relationship to patient _____
Date of birth_____ Insured's social security no. _____
Insured's employer name_____ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name_____ Insurance co. phone _____
Address (Street, City, State, ZIP) _____
Group no. (Plan or Policy no.)_____ Insured's I.D. no. _____
Insured's name_____ Relationship to patient _____
Date of birth_____ Insured's social security no. _____
Insured's employer name_____ Is insured a patient in our practice? ☐ Yes ☐ No

Payment is due in full at the time of treatment
(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. If the providers of the office are out-of-network with my insurance plan, I understand it is my responsibility to ensure that I have out-of-network benefits, and any balance for uncovered services will be my responsibility. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

*Signature*_____ *Date* _____

We'd like to know more about you so we can better serve you!

1. Do you prefer appointments in the (check all that apply):

☐ Early morning ☐ Early afternoon ☐ No preference
☐ Late morning ☐ Late afternoon ☐ Other: _____

2. Would any of the following help to make your experience here more enjoyable?

☐ Blanket ☐ Earplugs ☐ Quiet music
☐ Sunglasses ☐ Neck pillow ☐ Louder music

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date_____ Initials _____

DENTAL ARTS ON ESSEX
DR. MADELINE NIZIAK • DR. HANNAH NOYES

Smile Analysis

1. **Do you love the way your smile looks?** ☐ Yes ☐ No
2. **Do you feel comfortable showing your teeth when you laugh or smile?** ☐ Yes ☐ No
3. **If you could change anything about your smile, it would be (check all that apply):**

☐ Color of your teeth ☐ Too much or too little of teeth show when you smile ☐ Gaps between your teeth

☐ Size/Shape of your teeth ☐ Too much or too little of gum shows when you smile ☐ Alignment of your teeth

☐ Other: _____

4. **Do you have (check all that apply):**

☐ Sensitive or receding gums ☐ Worn/broken/chipped teeth ☐ Old or discolored fillings ☐ Missing teeth

☐ Old crowns that have dark edges at the top ☐ Other: _____

5. **In your line of work or lifestyle, do you (check all that apply):**

☐ Visit businesses or clients ☐ Travel ☐ Speak publicly ☐ Other: _____

6. **If you had a smile makeover, do you think you'd feel (check all that apply):**

☐ More confident ☐ More optimistic ☐ Healthier

☐ Just OK ☐ No different ☐ Other: _____

7. **Do you or someone in your family have issues with any of the following (check all that apply):**

☐ Chronic bad breath ☐ Grinding teeth ☐ Snoring

☐ Other: _____

STOP-BANG Sleep Apnea Questionnaire

Please circle YES or NO

STOP		
Do you **SNORE** Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	**YES**	**NO**
Do you often feel **TIRED**, Fatigued, or Sleepy during the daytime (such as falling asleep during driving)?	**YES**	**NO**
Has anyone **OBSERVED** you Stop Breathing or Choking/Gasping during your sleep?	**YES**	**NO**
Do you have or are being treated for High Blood **PRESSURE?**	**YES**	**NO**

BANG		
BODY Mass Index more than 35 kg/m2?	**YES**	**NO**
AGE older than 50 years old?	**YES**	**NO**
NECK size large? (Measured around Adams apple) *For male, is your shirt collar 17 inches / 43 cm or larger? For female, is your shirt collar 16 inches / 41 cm or larger?*	**YES**	**NO**
GENDER = Male?	**YES**	**NO**

FOR OFFICE USE ONLY

Scoring Criteria: For general population

Low risk of OSA: Yes to 0-2 questions

Intermediate risk of OSA: Yes to 3-4 questions

High risk of OSA: Yes to 5-8 questions or **Yes to 2 or more of 4 STOP questions + male gender** or **Yes to 2 or more of 4 STOP questions + BMI > 35kg/m2 or Yes to 2** or **more of 4 STOP questions + neck circumference 17 inches / 43cm in male or 16 inches / 41cm in female**

DENTAL ARTS ON ESSEX
DR. MADELINE NIZIAK • DR. HANNAH NOYES

General Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during, and after treatment, including all historical and current medical conditions and medications that you are taking.

It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided
    - **a.** I understand that during my course of treatment that the following care may be provided: Examinations, Preventive Services, Diagnosis, Basic Restorative and Crowns. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis. Patient Initials: _____
    - **b.** Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. Patient Initials: _____
2. Drugs and Medications
    - **a.** I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials: _____
    - **b.** I agree to the use of local anesthetics, sedatives, and other medications only as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. Patient Initials: _____
3. Changes in Treatment Plan
    - **a.** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials: _____
4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials: _____

_____

Patient Printed Name & Signature Date

_____

Signature of Dental Arts on Essex Employee Date

DENTAL ARTS ON ESSEX
DR. MADELINE NIZIAK • DR. HANNAH NOYES

OFFICE EXPECTATIONS

We are delighted to welcome you to our office and we look forward to helping care for your dental health!

APPOINTMENTS

Our office reserves specific time for your appointments. The doctors and staff are ready to serve your needs at any time. We confirm all appointments whenever possible; however, our **expectation** is that the patient will make every effort to keep the appointment. _____ Initial

CANCELLATIONS

If a cancellation is necessary, we **expect** at least a 48-hour notice. If this courtesy is not extended to us, we reserve the right to charge a $50.00 fee for the broken appointment. _____ Initial

RECALL VISITS (CHECK-UPS)

We believe the best way to keep you healthy is with regular preventive dental care. Recall visits catch small problems before they become more complex. The comprehensive cleaning removes harmful deposits on your teeth, which cause gum disease. Therefore, staying on a regular recall schedule is a great investment in maintaining your dental health. At each recall visit, we will recommend when you should return for your next visit. At that time, you may choose to make the actual appointment or ask to be notified when you are done. Our **expectation** is that you comply with our recommendations so that we may exceed **your expectation** in achieving optimum oral health. _____ Initial

EMERGENCIES

In order for us not to take time away from our regularly scheduled patients, emergency time is available daily. You can help by calling us as early in the day as possible. You can **expect** to be seen as soon as possible. _____ Initial

INSURANCE

As a courtesy to you, we will be happy to submit your dental insurance claims for you at the time of your visit. However, we will ask on a regular basis for you to verify your insurance as to any changes that may occur. We do request the estimated payment of your portion not covered by insurance at the time of treatment. Your co-payment is an estimated payment and any difference of charges will ultimately be your responsibility. Again, the estimated portion is based on the information that your insurance company provides to us. You may end up owing more or less depending upon the insurance payment received. We will send for a pre-treatment estimate for larger treatment plans so that you will know ahead of time what the insurance company will pay and we will go over the financing/expected payment at the time the pre-treatment estimate is returned. Our **expectation** is that if you provide us with all the necessary insurance information **you can expect** to have your insurance billed within the timely filing limit and we **expect** you, the patient, to pay at the time of service the amount that would not be covered by your insurance. _____ Initial

FINANCIAL ARRANGEMENTS

We **expect** payment in full at time of service. You can **expect** us to do everything possible to inform you in advance of the cost of your dental needs and we **expect** you to come prepared to pay your out of pocket expense.

I have read, understand, and agree to the above.

_____

Patient Name & Signature Date

DENTAL ARTS ON ESSEX
DR. MADELINE NIZIAK • DR. HANNAH NOYES

INSURANCE

We all know that insurance can be a very confusing issue. It is our policy to bill your insurance company and follow up until we get a satisfactory explanation from them regarding your claim. We try to estimate your responsibility as best we can, based on the information that we receive from your insurance company, as well as from you, the subscriber.

Sometimes it is unavoidable to bill you after the insurance company pays, because the amount paid by your insurance company is much lower than we have anticipated. Many routine dental services are not covered by insurance carriers and many insurance companies will often down-code, or apply an alternate benefit to a procedure in order to pay less. There is no exact science as every insurance/insurer is different depending upon which option/plan you or your employer(s) have chosen, and we have no way of knowing that information.

We need all of our patients to be aware of the fact that although we do our best to accommodate all of our insured patients, we cannot guarantee that payment will be made by your insurance company. **Any issues beyond our control are the patient's responsibility.**

On very large procedures or cases, or when absolutely necessary, we will submit a pre-treatment estimate for the patient so that we may have a clearer picture of the patient's responsibility. Again, your insurance company will tell you that this is **not** a guarantee of payment from them, but a general estimated figure of what the patient will be required to pay. Under no circumstance are the pre-treatment estimates a guarantee of payment from the insurance company down to the exact dollar amount.

Please rest assured that we will exhaust all measures to collect from your insurance company first. However, if insurance has not paid within 90 days of the procedure(s), the balance will return to the patient to contact their insurance company for further information.

Thank you and we sincerely appreciate your understanding of this matter.

Your signature indicates that you understand our policy as we have explained above, and that you agree to pay any outstanding balance not covered by insurance.

_____

Patient Name & Signature Date

_____

Signature of Dental Arts on Essex Employee Date

DENTAL ARTS ON ESSEX
DR. MADELINE NIZIAK • DR. HANNAH NOYES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgment

I have received a copy of the Notice of Privacy Practices of Dental Arts on Essex. I hereby authorize, as indicated by my signature below, to use and to disclose my Protected Health Information (PHI) for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication (you may check more than one):

- ☐ Contact me at my home phone #: _____
- ☐ Contact me at my cell phone #: _____
- ☐ Contact me on my work phone #: _____
- ☐ Send me an email at: _____
- ☐ Other: _____

I hereby authorize Dental Arts on Essex to send correspondence and x-rays to a specialist via email in an unencrypted format.

_____ _____

Signature Date

Please list any authorized person(s) with whom we may discuss your PHI in addition to custodial parents and legal guardians:

1. _____ Date added/Removed _____
2. _____ Date added/Removed _____
3. _____ Date added/Removed _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication(s) barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify

Staff Initials _____