RUDNICK DENTISTRY
TRANSFORMING LIVES through EXCEPTIONAL DENTISTRY

WELCOME TO OUR OFFICE

Our practice is dedicated to providing technically excellent comprehensive dental care in a relaxed and caring environment. Our goal is to work with you in keeping your smile for a lifetime.

Comprehensive Services

We provide all the latest techniques in cosmetic dentistry including cosmetic porcelain veneers, cosmetic metal free porcelain crowns, & teeth whitening. Our practice also offers a complete range of restorative care including porcelain crowns, fixed porcelain bridgework, removable dentures, root canal treatment and implant resto-rations. Dr. Rudnick has extensive knowledge in implant dentistry with the ability to surgically place & restore dental implants in your office. We also provide non-surgical treatment for periodontal (gum) disease as well as all types of preventive care.

Appointment Scheduling

Patients are seen by scheduled appointment only. If your are unable to keep a scheduled appointment, we ask that you give us the courtesy of at least 48 hours notice. Doing this will allow us to schedule other patients who are waiting for necessary treatment. We realize that unforeseen circumstances often arise. A $40 charge will be applied to your account for late cancellation of a scheduled appointment.

Emergency Care

Emergencies are seen by appointment as soon as possible during scheduled office hours.

If an emergency arises after hours, the Doctor can be reached through our answering service at the office number **(561) 625-1991.**

Office Hours

Our office hours are Monday through Thursday from 9:00 AM until 5:00 PM, and Fridays from 9:00 AM until 1:00 PM.

Financial Policy

We accept cash, check, Visa, MasterCard, Discover and American Express. Payment is due at the time of your visit. As a courtesy to our patients, we do submit and accept dental insurance towards payment of fees. You will be requested to pay any applicable co-payments, deductible or non-covered charges at the time of service. Fees for larger restorative or surgical procedures should be discussed with our Financial Administrator prior to scheduling your appointment.

Continued Next Page

Patient Information

Date: _____ Preferred Name: _____

Name: _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ SSN: _____

Contact Numbers

Daytime Phone: _____ Email: _____

Evening Phone: _____ Cell Phone: _____

Place of Employment or School? _____

Whom may we thank for referring you to our office? _____

Medical History (check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cardiac Transplant
- ☐ Cold Sores
- ☐ Congenital Heart Condition
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ History of Infective Endocarditis
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pregnancy – Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Amoxicillin Allergy
- ☐ Penicillin Allergy
- ☐ Clindamycin Allergy
- ☐ Erythromycin Allergy
- ☐ Latex Allergy
- ☐ Novocaine/Lidocaine Allergy
- ☐ Epinephrine Allergy
- ☐ Other

_____

_____

	YES	NO
Are you under a physician's care? Why? _____	☐	☐
Are you taking any medications? What? _____	☐	☐
Are you allergic to any medications? What? _____ (Examples: Penicillin, Sulfa, Codeine, Latex, Metals, Acrylic)	☐	☐
Are you pregnant or trying? _____	☐	☐
Contraceptives? _____	☐	☐
Have you had a serious accident or hospitalization? _____	☐	☐
Normal blood pressure if known? _____	☐	☐

Continued Next Page

Dental History (check the appropriate boxes)

How healthy do you want us to get your mouth?

☐ Don't care ☐ Average ☐ The best it can be

At what point do you want to initiate treatment?

☐ When my tooth hurts or breaks ☐ When something is worsening ☐ When something isn't ideal

What quality of dentistry do you want Dr. Rudnick to recommend?

☐ Just patch it ☐ Average ☐ Ideal, the best

What about your smile would you like to change?

	YES	NO
If we could show you an easy and safe way to lighten your teeth, would you be interested?	☐	☐
Modern dentistry allows us to invisibly straighten teeth! Does this interest you?	☐	☐
Do you have a specific dental problem?	☐	☐
Describe: _____	☐	☐
Do you have regular dental care? Last visit? _____	☐	☐
Do you think you have decay, gum disease or jaw problems?	☐	☐
Do you floss? How often? _____	☐	☐
Do your gums ever bleed?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have any loose teeth?	☐	☐
Do you ever have clicking, popping, or discomfort in your jaw joint?	☐	☐
Do you ever clench or grind your teeth?	☐	☐
Have you ever had a bad experience with a dentist?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Name of previous dentist and location: (optional) _____		

Last date of X-Rays: _____ Bite Wings: _____ Panorex: _____ Full Series: _____

Symptoms (check all that apply)

- ☐ Headaches
- ☐ TMJ Pain
- ☐ TMJ Noise
- ☐ Limited Opening
- ☐ Ear Congestion
- ☐ Facial Pain
- ☐ Tender, Sensitive Teeth
- ☐ Difficulty Chewing
- ☐ Neck Pain
- ☐ Postural Problems
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Difficulty Swallowing
- ☐ Loose Teeth
- ☐ Clenching/Bruxing
- ☐ Bells Palsy
- ☐ Tingling in Fingers
- ☐ Hot & Cold Sensitivity
- ☐ Nervousness
- ☐ Insomnia
- ☐ Trigeminal Neuralgia
- ☐ Back Pain

Continued Next Page

Family Information

Father (or Husband)

First Name M. Last Name

Street

City State Zip

Home Phone Work Phone

Birth Date: _____ Socia Security # _____

Mother (or Wife)

First Name M. Last Name

Street

City State Zip

Home Phone Work Phone

Birth Date: _____ Socia Security # _____

In Case of Emergency

(outside of immediate household or family):

First Name M. Last Name

Street

City State Zip

Phone

Account & Payment

Person Responsible for Account:

X _____

Preferred Method of Payment

- ☐ Cash/Check
- ☐ Credit Card
- ☐ Alternative Billing Source (ask)

Continued Next Page

Insurance Information

Primary Insured

Last Name M. First Name

Street City State Zip

Home Work Cell

Email Birthdate

Relationship to Patient

Employer Dental Ins. Co.

SS# Subscriber# Group#

Secondary

Last Name M. First Name

Street City State Zip

Home Work Cell

Email Birthdate

Relationship to Patient

Employer Dental Ins. Co.

SS# Subscriber# Group#

Authorization *(to be completed by all patients)*

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 the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I consent to the taking of photographs, during and after treatment, and to use of the same by the doctor in scientific papers, advertising or demonstrations.

X _____

Patient or Responsible Party

Date State Driver's License#

Continued Next Page

FINANCIAL POLICY AND DENTAL BENEFITS

We are committed to providing you with the best possible care. If you have dental benefits, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance, and your understanding of our financial policy.

Payment for services is due at the same time services are provided unless other payment arrangements have been cleared in advance. We accept cash, check, debit cards and credit cards. We also have financing options offered through Care Credit and Springstone Financing.

Returned checks will be charged at the rate as provided by state law. Charges may occur for broken appointments (no show) and appointments canceled without 24 hour advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your dental benefit plan. You must realize however that:

1. Your insurance is a contract between you, your employer, and the insurance company. **WE ARE NOT A PARTY TO THAT CONTRACT.**

2. We strive to provide you with the best and most ethical care for your dental health needs. Not all services are a covered benefit in all insurance/health maintenance organizations (HMO) contracts. These procedures include, but are not limited to: Cosmetic Dentistry, Full Mouth Reconstruction, LVI Orthotics, Esthetic Composite Restorations, CEREC Restorations, eMax restorations, Laser Treatments, High Grade Porcelain for Crowns and Bridges, Cosmetic Gingival Recountouring, and NiTi Endodontic Therapy. I understand that the dental codes associated with these procedures are for internal coding purposes to provide the best care possible and are not recognized by my dental benefit/HMO plan or the American Dental Association. This is to provide you with the best dental care possible. If you want patchwork dentistry, we are not the office for you.

3. Health Maintenance Organizations (HMO's) and other reduced fee plans are not insurance, they are benefits that may help offset your costs.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of service rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

A minimum non-refundable deposit of 20% of your estimated treatment cost is required to reserve your dental appointment.

Once you have signed a dental treatment plan, and dental treatment has started, you will be obligated to pay all costs and fees associated with your treatment plan as well as any additional treatment that may arise while undergoing your dental procedure.

I understand and agree that (regardless of my benefits) I am ultimately responsible for the balance on my account for any professional services rendered. I also agree to be responsible for any reasonable collection costs or attorney fees incurred in collecting a delinquent account. I have read and understand all the information on this sheet.

Name: (please print) _____ Date: _____

Signature: _____