Dr. Jeffrey N. Suffoletta
Functional Aesthetic Dentistry

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Welcome to our dental family. By scheduling your first appointment with Dr. Suffoletta you have taken the first step to achieving optimum dental health.

As a new patient, our concern for your dental care begins with a dedicated appointment to help us co-discover your unique baseline condition. While assessing the past and current health of your mouth, Dr. Suffoletta may also recommend photos, radiographs or models he feels are indicated. With these tools, we can direct you along the road to complete oral health while helping you achieve the best possible return for your investment in dentistry. The greatest service we could possibly give begins with the complete dental examination.

Please feel free to ask questions of any of our team. We are all here to help you and look forward to joining you in your pursuit and success in achieving lifetime dental health. We also encourage you to check out our practice website at www.DrSuffoletta.com along with our Yelp and Facebook page. Feel free to browse through and learn more about our innovative practice and philosophy of care. If you would like to contact us by email we can be reached at teamsuf@gmail.com.

Again, welcome to our practice. As a gentle reminder we offer dedicated time with our clinicians one patient at a time. If you are unable to commit to your reserved appointment we require a 48 hour notice so that we may serve other patients. We appreciate your commitment to us and look forward to serving you soon.

Sincerely,

Dr. Suffoletta and Team

What Sets US Apart

Multiple Visit Dentistry is a Thing of the Past: We Have Cerec Technolgy

One of the biggest reasons that patients put off getting dental crowns, veneers, or other porcelain restorations is the time and multiple visits it takes to complete. If you have a busy schedule like many of us do, we can take a single digital impression and fabricate everything while you watch and have you finished in about an hour.

You Can Achieve a Straighter Smile

Traditionally, the teenage years were ideal for exploring teeth straightening options like braces. This left many adults uncomfortable with the thought of metal braces, leading them to believe that they had missed their opportunity. Today, teens and adults visit us regularly for clear aligner therapy. A revolutionary type of orthodontic treatment that is nearly invisible. Many of our patients prefer this modern system due to discreet nature and comfortable trays.

Dental Lasers Offer Unique Safety, Convenience of No Shots

Dr. Suffoletta has been a lifelong proponent of bringing technology into dentistry. We proudly offer minimally invasive laser treatments. Our team is specially qualified to offer Waterlase laser treatments which is a state of the art tool that gives safe, reliable and comfortable results. Discover a new way of dentistry with lasers.

Missing a Tooth? You Have Safe, Permanent Options.

Like any part of your body, teeth play an essential role in keeping you healthy. Living with a missing tooth can make you feel uncomfortable, not to mention making life difficult when you eat or speak. When a tooth is lost, the surrounding hard and soft tissues are negatively affected. Dr. Suffoletta offers a modern, safe and permanent solution for the replacement of one, or multiple teeth. As your family dentist, Dr. Suffoletta has incredible knowledge of your personal history, making him the perfect fit for your dental implant provider.

TIME 11:15 AM DATE 8/22/2017

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 11:17 AM | Dr. Jeffrey N. Suffoletta | Date 8/22/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

HEALTH CENTERED DENTISTRY

Levels of Dental Care:

Our goal is to help you become as healthy as **you choose** to be. In order to achieve this, we need to understand what your individual dental goals are. Please review the levels of dental care below and select the option that **best describes your dental health needs**.

***All levels are capable of upgrading materials and lab services by selecting "Upgrade Acceptance" on the following page.**

PLEASE SELECT ONLY ONE BELOW

☐ **LEVEL 1- Needs Based Care**
This level includes patients in crisis with an emergency or accident that is in need of **immediate help.** This level also includes patients who only seek treatment when something breaks or becomes uncomfortable. Patients at this level prefer short term solutions. **This is not the primary focus of our practice.**

☐ **LEVEL 2- Maintenance Care**
This level is for the patient who wants to stay in routine hygiene visits and address restorative treatment only when it is presented. This includes taking an active part in the prevention of present and future disease problems, but chooses repair solutions that are more short-range in duration. Usually they choose 2-5 year reparative or corrective treatment, knowing full well that the dental treatment performed today will be repeated in the future.

☐ **LEVEL 3- Optimum Care**
This option is for patients wanting the highest level of dental care which comes with the financial obligations that coincide with all recommended dentistry.
This level of care includes all preventative and necessary procedures that create the most esthetic and optimal occlusion. These procedures include orthodontic treatment, removal of amalgam fillings, implants, and upgraded lab services. These patients also choose a higher quality of products that have better esthetics, quality, and longevity. These patients are involved with the master planning and comprehensive examination for the long term formulation of optimal care. **For the insurance based patient, this option requires the "Upgraded Material" option on the following page.**

Patient Name:_____ Date:_____
Patient Signature:_____ Date:_____

CRA Form

First name:_____ Last name:_____ Date:_____

Adults and Children 6+

PATIENT USE

Risk Factors *Circle one:*

Saliva	NO	YES
Do you take medications daily? If so, how many?	☐	☐ (_____)
Do you feel as though you have a dry mouth at any time of the day or night?	☐	☐

Diet		
Do you drink liquids other than water more than 2 times daily between meals?	☐	☐
Do you snack daily between meals?	☐	☐

Biofilm		
Do you notice plaque build-up on your teeth between brushings?	☐	☐

CLINICIAN USE ONLY

CariScreen reading results:	☐ (0-1500)	☐ (1501-9999)

Disease Indicators *Circle one:*

New/Progressing visible cavitations?	☐	☐
New/Progressing approximal radiographic radiolucencies?	☐	☐
New/Active white spot lesions?	☐	☐
Is decay history a concern?	☐	☐

Risk Identification *Transfer information above to boxes below to determine risk.*

Healthy	+Risk Factors	+Disease Indicators / High CariScreen
☐ 1 - Low Risk	☐ 2 - Moderate Risk	☐ 3 - High Risk
CDT Code D0601	**CDT Code D0602**	**CDT Code D0603**

CARIFREE

Rev. 11

DENTAL HISTORY

Name _____ _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Jeffrey N. Suffoletta, D.M.D.

Office Policies and Financial Agreement

The following is a statement of our office policies and financial policies, which we ask that you read, agree to, and sign before any treatment is rendered.

Appointment Policy

The appointment you scheduled is reserved specifically for you. Any change in this appointment affects our other patients. If a cancellation is unavoidable, please call the office at least 48 hours in advance so that we may give that appointment time to another patient.

Please plan to arrive 10 to 15 minutes prior to your scheduled appointment time. This will allow time to complete any paperwork and assist us in seeing you at your scheduled appointment time.

If you arrive 15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.

We attempt to confirm appointments a week in advance however it is your responsibility to keep your scheduled appointment. A verbal confirmation is required to retain your scheduled reservation. Please respond to text, email or call from the office 10 to 2 days prior. If no verbal confirmation is obtained your reservation may be filled with a committed reservation. Broken or missed appointments affect many people. If you do not cancel your appointment at least 48 hours in advance or if you miss your scheduled appointment time, there will be a failed/cancelled appointment charge of $50 per hour of reserved time missed. Our office reserves the right to NOT schedule any subsequent appointments if broken/missed appointments become an issue. If failing or cancelling appointment times becomes habitual we will require a credit card on file with a deposit to reserve any further appointments.

Diagnostic Policy

X-rays are taken at regular intervals as they are necessary for your diagnosis and treatment. Please be aware some insurance companies have limitations regarding the frequency of x-rays taken. We are generally able to give you an idea of when x-rays are covered however the cost is ultimately your responsibility. A panoramic or 3D cone beam will be taken every 5 years and the appropriate bitewing and periapical x-rays will be taken every 6 months.

Financial Agreement

Most dental insurances have limitations and/or various degrees of co-payments and deductibles. The treatment that is recommended by our office is never based on what is covered by your insurance; your treatment **should not** be governed by your insurance contract. For example, an insurance carrier may reduce payment for tooth-colored fillings and posterior teeth and allow an alternate benefit of silver fillings. If this is the policy of your insurance carrier you will be responsible for the difference in fees from the composite to amalgam cost. Our Standard of Care is given across the board to all of our patients. If a procedure is diagnosed to restore your oral health to its healthiest state and the procedure is non covered by your dental benefit policy we will inform you to the best of our ability however this does not determine the treatment plan and these fees will become our patients financial responsibility.

Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. We will set aside, for 60 days, that part of the balance which the insurance is expected to cover. If your insurance carrier does not send payment within 60 days, the balance is then due and payable by you, unless other payment arrangements have been made.

At the time of treatment the patient/guarantor is responsible for the portion the insurance does not cover. When insurance payments are delayed, or less than anticipated, we will assist you with inquiries to your insurance carrier. However, insurance coverage is an agreement made between you and your insurance carrier; therefore the account is in your name and final responsibility for any unpaid balance will be yours. It is our experience that insurance carriers respond best when inquiries come from you, the patient.

We are happy to assist whenever possible but, you are expected to understand the exclusions, limitations, and specifics about your insurance plan. We will gladly give you an **estimate** of your cost based on the information provided by your insurance prior to treatment. We cannot predict the exact amount your insurance will pay, your insurance carrier will not even guarantee payment until a review of the claim is completed.

If an account balance has been incurred, we require all outstanding balances be paid in full

within 30 days after receipt of statement. If balance is not paid in full, an interest rate of 1.5% monthly (18% annually) will accrue.

For our patients without insurance coverage:

Payment is due at the time treatment is rendered. We accept Cash, Check, MasterCard, Visa, Discover, American Express, and CareCredit. A fee of $25.00 will be charged for any check that is returned.

Any account 90 days past due is subject to review and eligible to be sent to our debt recovery service. In the event your account is turned over to collections you will be liable for all collection charges including but not limited to attorney and legal fees, interest charges or collection fees.

I have read, understand, and agree to the above Office Policies, Diagnostic Policies and Financial Agreement.

Patient Name: _____

Patient Signature: _____

Date: _____

Flexible Financial Arrangements

Congratulations on your decision to improve your dental health. We understand that cost is a concern for most patients and we want to help you make the care you desire and need fit your budget. if you have dental benefits, we will gladly process your claims and estimate your portion not covered by your plan. The estimated amount not covered by dental benefits is due at the time of service and may be paid by one of the flexible options below.

We offer a 5% fee reduction for services paid in full at the time of scheduling when not using dental benefits.

Cash

Check

Visa/ Mastercard/ American Express/ Discover/ Debit

Care Credit

- A separate line of credit to cover your entire family's dental need
- A credit line can generally be established in less than 10 minutes
- Care Credit has an interest deferred option for up to 12 months
- No annual fees or membership fees

Other Options Include

- 90 day same as cash

We will do our very best to make arrangements that fit your comfort level and maximize any dental benefits you may have.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Jeffrey N. Suffoletta, D.M.D. for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that my diagnosis or treatment by Dr. Suffoletta may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment or health care operations of the practice. Dr. Suffoletta is not required to agree to the restrictions that I may request. However, if they agree to these restrictions I request, the restrictions are binding. I have the right to revoke the consent in writing at any time except to the extent that Dr. Suffoletta has taken action as received on this consent. My "protected health information" means health information including demographic information collected from me, created and received by my physician and any other healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present and future physical or mental health or condition and identifies me or there is a reasonable basis to believe they may identify me.

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

Patient Name:_____

Patient Signature:_____

Date:_____