Smile Design by Brian M. Olitsky, DMD
24840 S. Tamiami Trail, Suite #3
Bonita Springs, FL 34134
P. (239)-992-9929

Patient Information

Please present your drivers license and dental insurance card along with your completed paperwork.

Patient Name _____ Date of Birth _____

Home Address/city and zip _____ Phone Number _____

E-Mail _____ Cell Phone _____

Social Security # _____ _____

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

Dental Insurance Information

Primary Insured _____ Insurance Company _____

Primary's Date of Birth _____ Primary's S.S. # _____

ID# _____ Group # _____

Claims Mailing Address _____ Primary's Employer _____

Acknowledgement of receipt of notice of privacy practices.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before your decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. Our Notice is posted. You may request a copy of our Notice of Privacy Practices including any revision at any time by contacting:

Contact Person: Erin Olitsky **Phone**: 239-992-9929 **Fax**: 239-992-9939
Mailing address: 24840 S. Tamiami Trail, Suite #3 Bonita Springs, FL 34134

We reserve the right to change our privacy practices as described in our notice of Privacy Practices.
I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I have read and am aware that I may receive a copy if I so desire of this office's Notice of Privacy Practices.

Patient signature _____ Dated _____

Consent for dental treatment

I have read the general treatment consent and am aware that I may receive a copy if I so desire of this office's consent form.

_____ _____

Patient signature Date

Financial, Appointment and Dental Xray Policy Agreement

To avoid any misunderstanding regarding this policy, it is necessary for you to read and sign this financial, appointment and dental x-ray policy before treatment.

1. **Payment due at time of reserving service time**: It is our policy that payment is due at the time of reserving service time. We accept MasterCard or Visa for payment. Please fill out the Credit card authorization form.

2. **Insurance**: Dr. Olitsky is an out of network provider for all PPO dental plans. Your dental insurance company will send your insurance reimbursement directly to you. Most of our patients receive their reimbursement within 4 weeks. We will submit your insurance claims for you, however, this does not guarantee payment. All questions regarding your coverage and claim information should be directed towards your dental insurance customer service. All fees are patients responsibilities, however we will make a good forth effort to prepare your claims and insure you receive your benefits in a timely manner.

3. **Appointment Agreement**: It is important to us that patients show up for their scheduled dental appointments. Missed or broken appointments result in a loss of valuable time, which could be utilized to serve others. If a patient cancels within 48 hours there will be a charged amount depending on services scheduled.

4. **Rescheduling Appointments**: We understand that situations arise and occasionally an appointment must be rescheduled. If you need to reschedule, please call our office as soon as you know that you will not be able to attend your scheduled appointment, 48 business hours before the appointment time.

5. **Broken Appointments**: We always strive to run on time, unless If you are more than 15 minutes late for an appointment without calling ahead, this will be counted as a "broken appointment". When you arrive 15 minutes late, it may not allow the staff enough time to give you the quality care you deserve, and it would be unfair to keep our other patients waiting because of another's tardiness. **Broken appointments will accrue a fee depending on amount of operatory time and employees reserved for your procedure.**

6. **Dental X-rays**: Our standard of care includes updating any necessary x-rays yearly at dental hygiene appointments and taken as deemed necessary by Doctor with all other dental procedures. You have a right to refuse any dental treatment recommend, however, we will not conduct treatment in our office without the necessary x-rays to perform dental treatment. If you have recent dental x-rays at another office, it is your responsibility to obtain these records prior to your scheduled appointment.

I have read and agree to the above guidelines.

_____ _____

Patient / Authorized Signature Date

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury _____	☐	☐
2.	an allergic or bad reaction to any of the following:	☐	☐
	○ aspirin, ibuprofen, acetaminophen, codeine _____		
	○ penicillin _____		
	○ erythromycin _____		
	○ tetracycline _____		
	○ sulfa _____		
	○ local anesthetic _____		
	○ fluoride _____		
	○ chlorhexidine (CHX) _____		
	○ Iodine _____		
	○ metals (nickel, gold, silver, _____)		
	○ latex _____		
	○ nuts _____		
	○ fruit _____		
	○ milk _____		
	○ red dye _____		
	○ other _____		
3.	heart problems, or cardiac stent within the last six months _____	☐	☐
4.	history of infective endocarditis _____	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6.	pacemaker or implantable defibrillator _____	☐	☐
7.	orthopedic or soft tissue implant (e.g joint replacement, breast implant) _____	☐	☐
8.	heart murmur, rheumatic or scarlet fever _____	☐	☐
9.	high or low blood pressure _____	☐	☐
10.	a stroke (taking blood thinners) _____	☐	☐
11.	anemia or other blood disorder _____	☐	☐
12.	prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15.	breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16.	sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17.	kidney disease _____	☐	☐
18.	liver disease or jaundice _____	☐	☐
19.	vertigo (e.g. "the room is spinning") _____	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21.	hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____	☐	☐
22.	high cholesterol or taking statin drugs _____	☐	☐
23.	diabetes (HbA1c = _____) _____	☐	☐
24.	stomach or duodenal ulcer _____	☐	☐
25.	digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27.	arthritis or gout _____	☐	☐
28.	autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29.	glaucoma _____	☐	☐
30.	contact lenses _____	☐	☐
31.	head or neck injuries _____	☐	☐
32.	epilepsy, convulsions (seizures) _____	☐	☐
33.	neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____	☐	☐
34.	viral infections and cold sores _____	☐	☐
35.	any lumps or swelling in the mouth _____	☐	☐
36.	hives, skin rash, hay fever _____	☐	☐
37.	STI/STD/HPV _____	☐	☐
38.	hepatitis (type ____) _____	☐	☐
39.	HIV/AIDS _____	☐	☐
40.	tumor, abnormal growth _____	☐	☐
41.	radiation therapy _____	☐	☐
42.	chemotherapy, immunosuppressive medication _____	☐	☐
43.	emotional difficulties _____	☐	☐
44.	psychiatric treatment or antidepressant medication _____	☐	☐
45.	concentration problems or ADD/ADHD _____	☐	☐
46.	alcohol/recreational drug use _____	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness _____	☐	☐
48.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49.	taking medication for weight management _____	☐	☐
50.	taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51.	often exhausted or fatigued _____	☐	☐
52.	experiencing frequent headaches or chronic pain _____	☐	☐
53.	a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54.	considered a touchy/sensitive person _____	☐	☐
55.	often unhappy or depressed _____	☐	☐
56.	taking birth control pills _____	☐	☐
57.	currently pregnant _____	☐	☐
58.	diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6) ● ○ ●

DENTAL HISTORY

Patient 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 sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
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, not enough, or do you have difficulty swallowing or chewing 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. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
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 more than one 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 mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) 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 _____

Smile Design by Brian M. Olitsky, DMD PA

Exquisite Dentistry, Extraordinary Smiles

Phone: (239)992-9929
Fax: (239)992-9939

REQUEST TO RELEASE RECORDS

*For digital X-rays, please send to our office email. (smiledesigninfo@gmail.com)

(First and Last Name)

(Date of Birth)

(Home Phone) (Cell Phone)

I request the release of my records to Smile Design by Brian M. Olitsky, DMD PA

(Patient Signature) (Date)

*Bottom portion to be filled out by a previous or alternating dental office.

Last recall appointment :

Last seen in your office :

Radiographs:

Last complete series (FMX) :

Last bitewing series :

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BRIAN M. OLITSKY, DMD

PATIENT RELEASE FORM

I hereby authorize Dr. Brian Olitsky to release in the dental records of _____ to the *American Dental Association*,

(Patient's Name)

Department of Testing Services. The records will include copies of current radiographs, intraoral and extraoral photographs – photos of dental casts and any relevant dental materials or appliances, dental chart, and a brief medical/dental history. These records will be used for purposes of educational assessment only. My name and personal identification information will not be included in these records. I understand that this authorization is effective on the date signed below and that a copy of this authorization will be received upon my request.

_____ _____

Signature Date

SmileDesign
Exquisite Dentistry, Extraordinary Smiles.
BRIAN M. OLITSKY, DMD

PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by Dr. Brian Olitsky or staff. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media). By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me. I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images:
(please initial indicating YES or NO below)
_____ YES _____ NO
For educational purposes (medical teaching or training),
_____ YES _____ NO
For marketing and advertising purposes (website, print, digital, or social media),
_____ YES _____ NO

At my request, my photographs and/or video images will only be used as part of my medical record. I hereby release Smile Design by Dr. Brian Olitsky and its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via a written request submitted to Smile Design by Dr. Brian Olitsky or by completion of a new form.

Patient Signature: _____ Date:_____

CONFIDENTIALITY AGREEMENT

I am aware that, in my work with the American Dental Association's (ADA's) Department of Testing Services (DTS), I will have access to information that must remain confidential. I understand this requirement and agree to maintain the confidentiality of any materials, recommendations and discussions before, during and after any meetings or activities in which I serve. I further understand that I may be removed from my role in working with the ADA and/or DTS if I fail to keep confidential any exclusive information protected by secrecy that becomes known to me by reason of the performance of my duties.

Volunteer Initials ____

COPYRIGHT AGREEMENT

I am aware that, in working with the American Dental Association's (ADA's) Department of Testing Services (DTS), I may have access to, work with, or develop copyrighted or copyrightable materials. I acknowledge and agree, individually and collectively, that all such materials belong solely to the ADA and that the ADA holds any and all rights to obtain and retain ownership of copyrights for such materials in its own name. I acknowledge and agree that any and all contributions I make to such materials will be original works, not copies in whole or in part of works of third parties. I acknowledge and agree that the ADA is the sole owner of such materials, and that I have no ownership rights whatsoever in such materials, the ADA has all rights to obtain copyrights for such materials, and such materials constitute "work made for hire" under copyright laws. I assign any and all ownership rights I may have to the ADA, and I agree that I will execute any additional documents necessary to effect this assignment to the ADA upon request.

Volunteer Initials ____

In signing below, I agree to abide by all terms and agreements set forth in this agreement.

_____

Signature Date

_____

Name (Print Legibly)