aesthetic
ORAL HEALTH
Peter A. Tzendzalian, DDS

Location:
Shannon Summit
3608 Shannon Rd, Suite #205
Durham, NC 27707
Ph: 919.402.9200 • Fax: 919.287.2525

Mailing Address:
PO Box 51127
Durham, NC 27717

New Patient Dental Questionnaire

Aesthetic Oral Health is committed to helping each patient reach their personal dental goals. Please assist us by completing the following questionnaire.

I entered this practice to obtain: (Please check all that apply)

___ **Comprehensive Examination** of my entire mouth and a consultation concerning my treatment options
___ **Sedation Dentistry** (we offer all of the following options: nitrous (laughing gas), pill sedation or IV sedation)
___ **Smile Design Consultation** to learn more about my cosmetic treatment options
___ **Emergency Exam** for a specific area of concern:
Are you in pain? ___Yes ___ N Please describe location and circumstances: _____
___ **Second Opinion** concerning treatment options presented elsewhere
___ **Other:** Please explain: _____

What are your present dental concerns? _____

I experience the following with my teeth/mouth: (Please check all that apply)

_____ Tenderness/Pain when chewing
_____ Food caught between teeth, where?____
_____ Loose teeth, where?_____
_____ Recurring sores in or around mouth
_____ Bleeding sore gums
_____Missing teeth
_____ Jaw aches/feels tired/soreness
_____ Clenching/grinding
_____ Jaw clicking/popping
_____ Floss breaking-Explain where:_____
_____ Bad breath, unpleasant taste
_____ Sensitive Teeth

I consider my smile: ____ Very appealing ____ In need of improvement
____ Nice ____ Acceptable to me

I would rate the condition of my teeth and gums: ____ Very good ____ Acceptable
____ In need of treatment ____ In need of extensive treatment

What are your dental expectations? _____

I would rate the <u>value</u> I place on my oral health as: ____ Very Important to me, want to be healthy
____ Moderately important to me
____ Very low importance to me, as long as not in pain

I have concerns in pursuing future dental treatment: ____ Yes ____ No

My Concerns are: _____ I am fearful of dental treatment, Please explain:_____
_____ Financial (payment plans are available upon approved credit)
_____ Scheduling concerns, Please explain: _____
_____ Other, _____

I would rate my previous dental experiences and quality of care:
____ Exceptional ____ Average ____ Below average ____ Poor

Past Dental History:
I have avoided dental care in the past: ____ Yes ____ No If yes, Why? _____

Date of last dental visit:_____ Where: _____

On that visit I had: ____ Routine Cleaning ____ X-Rays ____ Fillings ____ Emergency Care ____Extractions

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PATIENT REGISTRATION INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)_____

DOB: ____/____/_____ SSN# _____ E-mail _____

Spouse's Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm Phone # _____

Wk# _____ Cell # _____

DOB: ____/____/_____

SSN# _____ Relationship: _____

YOUR PREFERENCES

Do you prefer appointment reminders by:
[ ] Email [ ] Text

Do you prefer to receive calls from our office at:
[ ] Cell [ ] Home [ ] Work

Whom may we thank for referring you?
_____

How do you wish to be addressed by our staff?

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group #_____

SUPPLEMENTAL INSURANCE (DENTAL):

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

Dr. Tzendzalian is one of the most advanced CAD/CAM dentists in the U.S. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

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**Dr. Tzendzalian offers sedation for all dental procedures.
Dental Implants, Veneers, TMJ pain treatments and general dentistry for all ages!**

MEDICAL HISTORY and CONSENT Patient Name : _____

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____

_____

Women:

Pregnant	Y	N
Due Date _____		
Nursing	Y	N

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (Ringing)	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

General

Current weight: _____lbs

Height: _____ ft _____in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Do you wear removable teeth?	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
How often? _____		
Has anyone told you that you snore?	Y	N

Social History

Do you smoke? N Y ___ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? Y N

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Peter A Tzendzalian, DDS

MEDICAL HISTORY and CONSENT Patient Name : _____

List any medications you are taking:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

_____

_____

_____

_____

Primary Physician's Name: _____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Peter A. Tzendzalian, DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Peter A. Tzendzalian, DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Peter A. Tzendzalian, DDS choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Peter A. Tzendzalian, DDS. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Peter A. Tzendzalian, DDS and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

SIGNATURE OF CONSENT

Name of Patient _____ _____ **Date** _____
Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ **Date** _____
Signature of Parent/Guardian

NOTICE OF PRIVACY PRACTICES

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ _____
Signature of Patient **Date**

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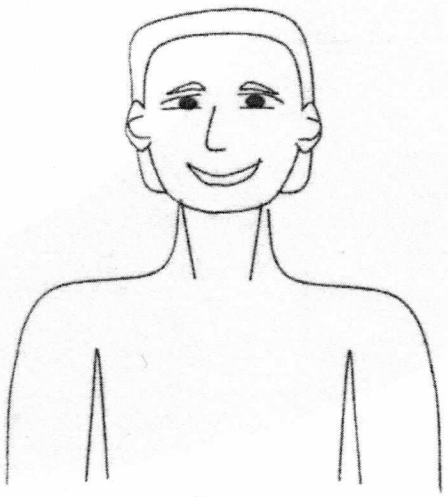
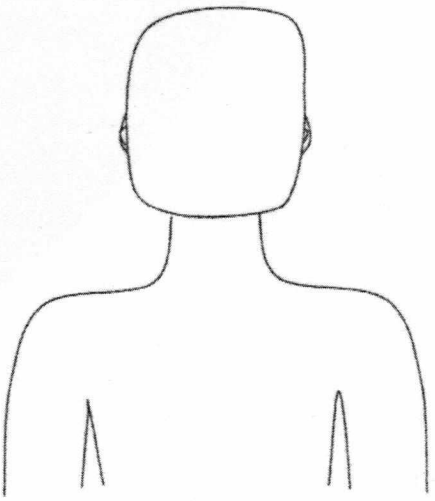
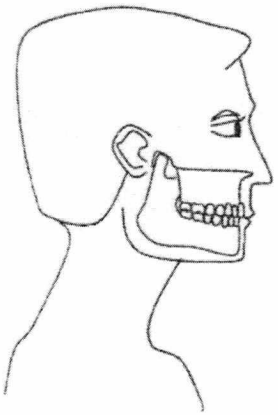
Mark areas where you are experiencing any discomfort



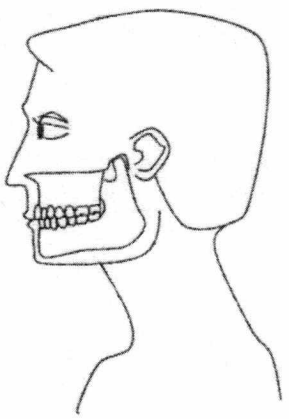
Front



Back



Right side



Left side

Do you experience any of the following (check all that apply)?

- ☐ Clicking/popping jaw joints
- ☐ Head pain
- ☐ "Migraine" type headaches
- ☐ Ringing in your ears
- ☐ Vertigo or dizziness
- ☐ Neck pain
- ☐ Arm and/or finger numbness and/or pain
- ☐ Difficulty swallowing
- ☐ Clenching and/or grinding of your teeth
- ☐ Can't find your comfortable bite
- ☐ Limited opening of your mouth
- ☐ Pain behind your eyes

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Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1 Do you like the appearance of your teeth and your smile? □**Yes** □**No**
If not, explain _____

2 Are your teeth all in alignment (straight)? □**Yes** □**No**
If not, explain _____

3 Do you have spaces that you don't like? □**Yes** □**No**
If yes, explain _____

4 Do you like the color of your teeth? □**Yes** □**No**
If not, explain _____

5 Do you like the shape of your teeth? □**Yes** □**No**
If not, explain _____

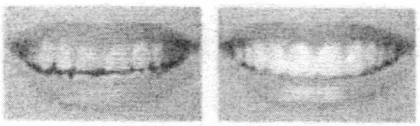
6 Are your teeth...
Chipped □**Yes** □**No** Protruding □**Yes** □**No** Hidden □**Yes** □**No**
If yes, explain _____

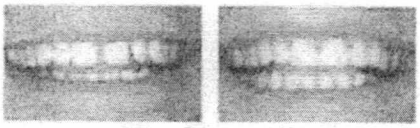
7 Are your teeth wearing on the biting surfaces? □**Yes** □**No**
If yes, explain _____

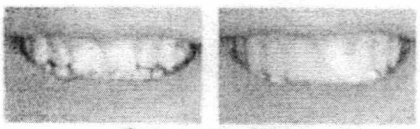
8 Are there old fillings or dental work you don't like looking at? □**Yes** □**No**
If yes, explain _____

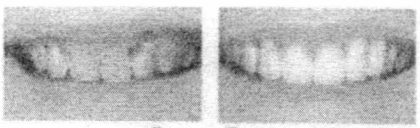
9 What would you like to change the most in the appearance of your teeth?
_____

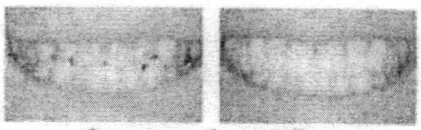
10 How would you like your teeth to look
_____

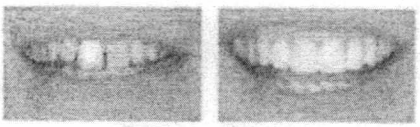

Stained and Chipped


Spaces


Calcification Stains


Fanged Teeth


Stained and Crooked Teeth


Porcelain Crowns


Beautiful Smile

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Authorization for Release of Information – Compound Release

Name of Patient_____Date of Birth _____

Peter A. Tzendzalian, DDS dba Aesthetic Oral Health is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Other person (s) (provide name, relationship)	☐ Financial ☐ Dental/Medical
☐ Email communication -*_____ ☐ Text communication – Number * _____ *Please accept the disclosure below ☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	☐ Financial ☐ Dental/Medical ☐ Appointment reminders/notes ☐ Breach notification
☐ Voice Mail	☐ Results of x-rays/ lab results
PHOTOS:	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Revised Jan 2018

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Peter A. Tzendzalian, DDS, PA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY Peter A. Tzendzalian, DDS, PA AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(OVER)

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YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve you care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

AOH Privacy Officer Name or Title: AOH Practice Administrator
Email Address: smiles@drpetert.com
Phone Number: 919-402-9200

Effective date: 12/15/2008 Revision Date: 10/25/2018

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Authorization to Release Health Information

Name of Patient _____ Date of Birth _____

Address _____

_____ **may release the following information:**
(Name of the Practice/Doctor/entity)

☒ Recent Complete Radiographs ☐ Charting ☐ Office visit notes

Entity or person who will receive the information:

Name Peter A. Tzendzalian, DDS, PA_dba Aesthetic Oral Health

Address 3608 Shannon Rd, #205, Durham, NC 27707

Email: smiles@drpetert.com Phone 919-402-9200

☒ **Send the information electronically. Email address:** smiles@drpetert.com

☒ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2016