



Date: _____

World-Class Smiles – Often Overnight!

www.aestheticdentaldesigns.net & [.com](http://www.aestheticdentaldesigns.com)

Welcome to Aesthetic Dental Designs. Would you please be kind enough to answer the following questions? Please let our concierge know if we might tempt you with gourmet coffee, juice, wine, or cocktail. Thank you so much for being our guest!

 Name (Last) (First) (Middle) / / M F S M D W
 Date of Birth Sex Marital Status Social Security Number

 Home Address (Street) (City) (State) (Zip Code) Home Phone Number

 Name of Employer Occupation Driver's License Number

 Business Address (Street) (City) (State) (Zip Code) Business Phone Number

 Insured Member SSN Date of Birth Dental Insurance Co Relationship Subscriber's Employer

 In case of Emergency, call: Home Address (Close Relative) Home Phone (Close Relative)
 (Name of close relative *NOT*

 living at your home address.) Business Address (Close Relative) Business Phone (Close Relative)

 General health (please check): EXCELLENT GOOD FAIR POOR Name of physician _____

 Physician's address _____ telephone number _____ date of last physical _____

 Are you pregnant? Yes No . If yes, expected delivery date: _____

 Do you smoke? Yes No . If yes, how much? _____

 Are you allergic to any medications? Yes No . If yes, names of medications _____

 Are you taking any medication now? Yes No . If yes, names of medications and problems for which they are taken:

 Medication 1) _____ Taken for _____ 3) _____
 2) _____ 4) _____

Have you ever had (please check-mark appropriate boxes):

- | | |
|---|---|
| Heart disease..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Cancer Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic fever..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Mitral valve prolapse Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Abnormal blood pressure..... High <input type="checkbox"/> Low <input type="checkbox"/> No <input type="checkbox"/> | Night sweats..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Ulcers..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart murmur Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Tuberculosis or lung disease Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaundice Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Drastic weight loss Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Epilepsy Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma or hay fever Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus trouble Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital heart lesions Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis..... Yes <input type="checkbox"/> No <input type="checkbox"/> | X-ray treatments for cancer..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Lymph node enlargement (swollen glands)..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Common cold..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Persistent diarrhea Yes <input type="checkbox"/> No <input type="checkbox"/> |
| AIDS..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Prolonged bleeding..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Fainting spells Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Excessive urination and/or thirst..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Swollen ankles Yes <input type="checkbox"/> No <input type="checkbox"/> |

 If you have entered "yes" to any of the above, please explain: _____

 What are your hobbies? Special Interests?

 How did you hear of Dr. Snyder?

 If patient was assisted with this form, Patient:
 Enter name of person assisting: _____
 Print name Sign name Date Sign name* Date

*your signature indicates you have received a copy of the HIPPA law and Dental Materials forms as well as releasing Dr. Snyder to utilize any dental photographs for lecturing and educational purposes.

DENTAL HEALTH and APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your *primary* concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?Yes No

Is so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

Do you have missing teeth? _____ If yes, have you had them replaced? _____

If you *have* had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____ What type of brush do you use? SOFT MED HARD

Do you avoid brushing any part of your mouth because of pain? Yes No . If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none Do you lose fillings or break fillings? Yes No

Do you chew on only one side of your mouth? Yes No If yes, explain: _____

Do your gums feel tender or swollen? Yes No Do you usually have many cavities?... Yes No

Do you clench or grind your jaws while sleeping or during the day? Yes No Do your jaws ever feel tired? Yes No

We respect your right to *choose* the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are *rarely* symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – *until* it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the *choices* available to achieve long-term health and beauty for your existing natural teeth. **Please check *all* that apply:**

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and *last* for a long time
- Spreading payments out over time may help me to achieve the excellent results I desire
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire
- I *am* interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now
- Although I am not interested in a plan for long-term dental health, I *do* desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please *rate* your smile from 1 to 10 (1= I hate my smile, 10= awesome) _____

Would you like to have whiter teeth? Yes No

If you had a *magic wand* what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any *special* occasions coming up? _____

Through state of the art technology of Cosmetic Dentistry, we have the ability to help you achieve a World-Class Smile, *often overnight...* Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes No . If yes, please check off all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____

At Aesthetic Dental Designs, though **our focus is on appearance-related dentistry**, our team also delivers routine general dental care as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm regards,
Todd Snyder

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Here at TCS Aesthetic Dental Designs, Our Office Policy regarding financing is as follows: As a condition of the treatment performed by the Providers of the office; financial arrangements must be made in advance for the full cost of proposed treatment. The practices' vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient parent-guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended; at the management's discretion; for payments in full with cash or money order. (Inquire for more details)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied.

I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond Dr. Snyder's control.

In consideration for the professional services rendered to me by the Doctor; at the providers recommendation or at my own request; I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to; by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Dr. Snyder and/or Dr. Snyder's financial coordinator, to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____



TODD C. SNYDER, D.D.S., P.C.

Oral Cancer Facts

The death rate for oral cancer is higher than that of cervical cancer, Hodgkin's disease, cancer of the brain, liver, testes, kidney, ovary, or skin cancer (malignant melanoma).

Some 30,000 Americans will be diagnosed with oral or pharyngeal cancer this year. It will cause over 8,000 deaths, killing roughly 1 person per hour, 24 hours per day. Of those 30,000 newly diagnosed individuals, only half will be alive in 5 years. This is a number that has not significantly improved in decades. If you expand the definition of oral cancers to include cancer of the larynx, for which the risk factors are the same, the numbers of diagnosed cases grow to 41,000 individuals and 12,500 deaths per year in the US alone. *The death rate associated with this cancer is particularly high due to the cancer being routinely discovered late in its development.*

Oral cancer is particularly dangerous because it has a high risk of producing second, primary tumors. This means that patients who survive a first encounter with the disease have up to a 20 times higher risk of developing a second cancer.

Oral Cancer Screenings need to be done twice a year. There are numerous new non-invasive technological advances to find oral cancer in its early stages. Please inquire about our non-invasive early cancer diagnostic tests from anyone of our staff members.

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Patient Referral Program

I want to help you and your friends to receive the best possible dental care available. There are so many exciting new materials and techniques to restore teeth that most people don't know exist. I value good people as I am sure you do too. I would like to offer to you and anyone you know that would value quality dentistry a wonderful opportunity to receive a special courtesy on dental care. We still have space available for new patients in our office and we would like to offer anyone you know that would value quality dentistry a wonderful opportunity to receive a special courtesy free dental consultation appointment for new patient care.

Todd C. Snyder, DDS, PC
President

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SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS.

At TCS Aesthetic Dental Designs, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits...

Your dental benefits are based upon a contract made between your employer and an employee benefits company. **If you have any questions regarding your dental benefits please contact your employer or the benefits carrier directly.**

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of \$1,000. **There has been no significant increase in the yearly maximum cap in 40 years!** However, there have been significant increases in your premiums. **Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.**

Many people receive notification from their insurance company that dental fees are "*above usual and customary.*" A dental benefits company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"**

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. **Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan.** You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

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