



We appreciate your interest in our dental practice. We'd like to help you find out if our dental practice is right for you.

You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our staff is friendly and attentive. All of our treatment is designed to be comfortable, to be long-lasting, and to exceed your expectations. We use the latest technology and techniques our profession has to offer.

Our biggest strength lies in how you are treated. We allow extra time so that you are never rushed. We want to know what we can do to develop the best possible professional relationship with you.

We provide state of the art cosmetic dentistry, but ***what does that mean?***

A large part of our practice involves the type of procedures you may have seen on television, such as whitening and porcelain veneers for your front teeth. In fact, Dr. Bernstein himself has performed these very procedures on television. However, ***cosmetic dentistry is also for back teeth***. This aspect of our practice involves replacing worn-out and unattractive dental work with beautiful, natural-looking porcelain restorations. If you have dark mercury-silver fillings, mismatched caps that appear dark at the gum-line, or chipped/broken teeth, we can help you.

Another important part of our practice is ***functional dentistry***. This involves helping people with TMJ/TMD. If you have worn-down teeth, headaches, clicking in the jaw joint, face/neck pain or bite problems, we can help you with that as well.

By filling out the enclosed questionnaires, we find out what areas of dentistry you are interested in. You may find that by combining our areas of expertise, you can achieve the best results. During the examination phase, we are here to show you what the possibilities are. Ultimately, whatever treatment you receive is your choice. We offer a variety of payment options to help meet your individual needs. Please take a moment to complete the enclosed forms and ***return them to us two days prior to your appointment***. This will greatly enhance your visit.

Because you are an active participant in your treatment, knowing what is important to you about your smile, both cosmetically and functionally, is helpful to us. We look forward to seeing you!

COSMETIC DENTISTRY

1375 GRAND AVENUE
S U I T E 2 0 1
PIEDMONT, CA 94610
PHONE 510.601.SMILE
PHONE 510.601.7645
FAX 510.601.7646
www.allnewsmiles.com

Sincerely,

Dr. Josh Bernstein and Staff

Health History

JOSHUA B. BERNSTEIN



Name _____ Date _____

Have you been hospitalized in the last 5 years? (Please check one) No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of medical care:

Medical physician currently providing you care:

Name _____ Phone (____) _____

- | | | | |
|---|--|-------------------------------------|--|
| Anemia or Blood Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis, Any Form | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Arthritis, Rheumatism or other inflammatory disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Joint Replacement When replaced? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Abnormal Bleeding from a cut | <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Disease (including Jaundice) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cancer or Tumor | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sore/Enlarged Lymph Nodes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Psychosis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Emphysema or other Respiratory/Lung Illnesses | <input type="checkbox"/> No <input type="checkbox"/> Yes | Previous Biopsies | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Radiation or Chemotherapy Treatment | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Fainting or Dizzy Spells | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Glaucoma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Slow-Healing Mouth Sores | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Unintentional Weight Loss or Gain | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Valve (artificial) or Heart Transplant | <input type="checkbox"/> No <input type="checkbox"/> Yes | H.I.V. Infection/AIDS or ARC | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Venereal Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Disease, Heart Attack or Heart Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | Other Conditions | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Stent? When placed? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Recurrent Illnesses | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Are you taking any of these medications?

- | | | | |
|---|--|--|--|
| Pre-medication before dental treatment? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tagamet® (cimetidine) or Prilosec® (omeprazole) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Antacids | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dilantin® or Tegretol® | <input type="checkbox"/> No <input type="checkbox"/> Yes | Serzone® (nefazodone) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Barbiturates | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diflucan® (fluconazole) or Sporonox® (itraconazole) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| St. John's Wort or Kava-Kava | <input type="checkbox"/> No <input type="checkbox"/> Yes | Biaxin® (clarithromycin) | <input type="checkbox"/> No <input type="checkbox"/> Yes |

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Health History — continued

JOSHUA B. BERNSTEIN



Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If yes, when did the treatment begin? _____
When did the treatment end? _____

Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking and dosages:

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Women: Are you pregnant? No Yes

If not pregnant, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother No Yes

Are you taking Birth Control Pills No Yes

Have you ever been diagnosed with "abnormal" or "high blood pressure?" No Yes

Are you allergic or have you had a reaction to:

Local Anesthetics No Yes

Penicillin or antibiotics No Yes

Codeine, Valium or other sedatives No Yes

Aspirin, Ibuprofen or Tylenol No Yes

Latex or Metals No Yes

Other (please specify) _____

Tobacco, Alcohol & Drugs

Do you use tobacco? If yes, circle type: smoke chew No Yes
How much per day? _____ For how long? _____

Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? _____ No Yes

Do you use any mood-altering drugs other than those previously listed? No Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health and medication.

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Patient (Print Name) (Patient Signature) Date

Doctor (Print Name) (Doctor Signature) Date

Comfort Menu

JOSHUA B. BERNSTEIN



Your comfort is our priority. We provide a variety of services to assure that you are comfortable at all times. Please select from the following menu if you prefer any of these options.

- Patients find that if they take an analgesic prior to treatment, it helps later in the day. Which do you prefer? Tylenol Advil Other

- We provide various levels of sedation to ease your mind. Would you benefit from a sedative? Yes No

If yes, we provide: Nitrous Oxide (laughing gas)

Mild sedative pill

Moderate sedative pill

I.V. Sedation (by a specially trained professional)

- The Wand is today's most comfortable numbing technology and we use it routinely. Used in combination with a topical medication from the dermatology profession, The Wand allows you to get numb feeling virtually nothing.
- Our rooms are equipped with video players and "virtual reality" movie glasses. Watching movies and videos is an excellent way to pass the time during your visit. Would you like to watch a movie? Yes No

What type of movies do you like? _____

We have movies available on site or please feel free to bring your own.

- Blankets help keep you warm and relaxed through your visit. Would you like a blanket? Yes No
- Pillows provide an extra measure of comfort whether you have a sore back or you would just like something to hold onto. Would you like pillows? Yes No
- A courtesy telephone is always available to you. Please let us know if you need to make a call and we will provide you with a portable telephone.
- Is there anything else we can do for you to make your visits as comfortable as possible? _____

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Our office is very unique and unlike any dental office you have ever been to. Your upcoming visit is an important first step toward getting the dentistry you seek. We place a high emphasis on helping you determine your present as well as your future dental needs, wants, and desires. Here are some things we are going to be talking about at your first visit. These are some issues you may not have considered before. Please answer these questions in a way that best expresses how you feel. Your answers will help us to prepare for your visit so that we may better serve you.

1. How can we help you? _____

2. What do you think is the current state of your mouth's health? _____

3. How healthy do you want us to get your mouth? (Check one):
 Pain relief/repairs only Average The best it can be
4. Tell us about your good dental experiences _____
and the bad ones _____
5. Why are you consulting with us rather than your previous dentist? _____
6. What about your smile would you like to improve? _____

7. What would it take for you to trust us to be your dentist? _____

8. Do you have any family or friends that already come to our office? Yes No
9. What do you already know about our office and what are your expectations? _____

10. Has fear ever been an issue for you in a dental office? Yes No
11. Has time ever been an issue for you in getting your dental work done? Yes No
12. Has the cost of dental treatment been a concern for you? Yes No If yes, what can we do to help you with this? _____
13. We have the unique ability to look at your mouth from three different perspectives. Which of these would you like us to use for you? (Please check all that apply):
 As a general dentist As a cosmetic dentist As a functional dentist
14. At what point do you want us to initiate treatment? (Please check one):
 When my tooth hurts or breaks When something is worsening When it's not ideal
15. What quality of dentistry do you want us to recommend? Repairs Average Ideal/the best
16. What additional information would you like us to know? _____

17. Your name _____
18. How did you find out about our office? (Please check all that apply):
 Personal referral from _____ Postcard Newspaper
 TV Internet Other _____
19. If you found us on the Internet, what search words did you use? _____

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Patient Information



Patient Name _____ BestTime to Call _____

Date of Birth _____ Social Security No. ____ / ____ / ____

Street Address _____

City _____ State _____ Zip _____

Sex: Male Female

Marital Status: Single Widowed Married / Spouse's Name _____

Occupation _____ Employer Phone (____) _____

Employer Address _____

Insurance Information

Subscriber's Name _____ Date of Birth _____

Subscriber's ID or SSN # _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Secondary Insurance

Subscriber's Name _____ Date of Birth _____

Subscriber's ID or SSN # _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Contact Information

Street Address _____

City _____ State _____ Zip _____

Telephone Numbers:

Home (____) _____ Cell (____) _____ Work (____) _____

Do you receive text messages on your cell phone? Yes No

Email _____

Emergency Contact Person:

Name _____

Tel (____) _____ Relationship _____

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