



Welcome to our practice!

We thank you for choosing our office for your dental needs. Did you know your oral health is a vital part of your overall well being? This is why we take a comprehensive approach when designing a treatment plan for your needs. Some of the services we offer include crowns, veneers, oral surgery, root canals and teeth whitening, just to name a few. Most procedures can be performed in our office, thus eliminating the need to travel to a different office for specialized treatment.

Throughout the year, our staff spends many hours attending continuing education courses to ensure that we are using the latest technology, techniques and resources available. This allows us to provide our patients with care that is not only cutting edge, but also time and cost effective as well.

On each and every visit, we will strive to make it a pleasurable experience. For your comfort, we offer televisions in every treatment room and refreshments in our reception area. If there is anything else we can do to makes your visits more pleasant, please let us know.

We thank you for choosing our office and look forward to seeing you soon.

Sincerely,

David Castellano, DMD

Jesus Sojo, DMD

We are located on the corner of Linebaugh and Countryway, behind the McDonald's.





Commonly Asked Questions

Q. Going to the dentist makes me anxious. Is there anything you can do to make me feel more comfortable?

A. This is a common problem that many patients face and will often prevent them from receiving much needed treatment, which will only result in additional problems later on. Your dentist will take ample time to explain the procedure, answer any questions you may have and make you feel at ease. For many patients, just knowing what to expect helps them to relax. For patients needing something additional, we do offer nitrous oxide, often referred to as laughing gas, to help you feel more comfortable. If necessary, we may also prescribe an oral sedative to be taken prior to your appointment.

Q. Do you offer payment plans?

A. We realize dental treatment can be costly, especially for patients without insurance coverage. While we do not offer in house financing, we do participate in the CareCredit program. CareCredit is a fantastic option for patients who are looking to make payments on a monthly basis. There are several different options including 0% interest financing for up to 12 months.

Q. I would love to have my teeth whitened, but isn't it expensive?

A. We offer a variety of whitening options to make it affordable for all our patients. We have whitening systems for as low as \$195.

Q. Do you take my insurance?

A. We are able to work with most insurance policies. Please call our office with your insurance information and we will gladly contact your insurance carrier to verify your benefits.

Q. Why are x-rays necessary and aren't they harmful?

A. X-rays are a vital tool in diagnosing common oral problems such as cavities, periodontal disease, abscesses and an array of other issues. Because many oral problems reside beneath the gums, between the teeth and under existing dental work, x-rays allow us to see what a visual exam does not. Just as your medical doctor orders yearly tests, we require yearly x-rays to give you a clean bill of oral health. Our office uses the latest technology in digital imaging to minimize any apparent exposure. The American Dental Association has performed countless research concluding that the radiation received from digital dental x-rays is far less than what people receive on a daily basis from naturally occurring elements.

As a courtesy, we will call you to remind you of the appointment which you have scheduled. We realize that your time is very valuable and do our best to minimize wait times. In return, we ask if you are unable to keep a scheduled appointment, you notify the office so we may offer our services to another patient in need. Appointments cancelled or missed with less than 24 hours notice may be subject to a fee.

We are committed to providing our patients with the best care and staying up to date on current advancements to improve our quality of care.



Financial Policy

As a courtesy to our patients, our office is happy to file your dental insurance for you and wait up to **30 days** for payment from them. If you prefer, we will collect the full amount due directly from you at the time of service and bill the insurance company for payment to go directly to you.

If you choose to have us wait for your insurance payment, we will collect the amount we **estimate** will be due from you at the time of service. Though we strive to be accurate, this is only an **estimate** and a balance may be due after the insurance has paid their portion. If you would like us to send a pre-determination of benefits we are happy to do that but it is still not a guarantee that the insurance will pay at the time of service.

After **30 days** or upon payment from your insurance company, the balance becomes due and payable in full by you. If a problem arises with the claim, we will continue to do whatever is necessary to see that you are reimbursed any amount still due to you by your insurance company.

Failure to pay your balance may result in a late fee of \$25.00.

Returned check fee \$40.00.

I have read the agreement above and understand the terms. I choose to have the payment paid directly to the provider of service.

Signature

I choose to pay the full amount due at the time of service and have the insurance payment come directly to me/ I don't have dental insurance.

Signature



Notice of Privacy Practices of Westchase Dental

The law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

The law permits us to disclose your health information to those involved in your treatment. For example, a review of your file by a specialist whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, if you have insurance, we may send a report of your progress to your insurance company. We may also share information with our business associates, such as a billing service. We will have a written contract with each business associate that requires them to protect your privacy. All records containing health or personal information will be shredded if no longer needed and all such retained information will be kept secure.

We may use or disclose your information to contact you. For example, we may send you newsletter or other information. We will also call to confirm the time and day we have reserved for your dental care. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. We may need to contact you from time to time. We will use whatever address and telephone number you prefer.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. We will need a signed request for the transfer. A reasonable fee may apply.

You have the right to see and receive a copy of your health information, with a few exceptions, in a timely manner without delays for legal review. Please give us a written request regarding the information you would like to see. If you also would like a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW Room 509 F, Washington, DC, 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Dr. David Castellano.

Acknowledgement

I have received a copy of the Privacy Practices Notice of Westchase Dental.

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient. _____



Welcome to our office! We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments or fees, please feel free to ask. This Acquaintance Form will help us to serve you better.

PLEASE PRINT

DATE: _____ EMAIL ADDRESS: _____

PATIENT'S NAME: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

SPOUSE'S NAME: _____

PATIENT'S ADDRESS: _____ ZIP: _____

PHONE: _____
 Home Work Cell Preferred

DATE OF BIRTH: ____ / ____ / ____ SOCIAL SECURITY # _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

DO YOU HAVE DENTAL INSURANCE? YES NO

NAME OF INSURANCE CO.: _____

POLICY HOLDER: _____ SOCIAL SECURITY # OF POLICY HOLDER: _____

DATE OF BIRTH OF POLICY HOLDER: _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

IF PATIENT IS A CHILD, PARENT OR LEGAL GUARDIAN NAME: _____

PURPOSE OF VISIT: _____ FORMER DENTIST: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IF REFERRED BY ANOTHER PATIENT, WHOM MAY WE THANK FOR REFERRING YOU? _____

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____ ADDRESS: _____

Medical History

Patient's Name: _____ Date of Birth: _____

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex
- Sulfa Drugs Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? Yes No _____

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: _____ Date: _____

Dental History

1. Are you having any discomfort at this time? _____
2. What concerns you the most? _____
3. When was your last dental visit? _____
4. Do any of the following cause tooth discomfort?
 HOT COLD SWEETS CHEWING
5. Do you have any sores in or around your mouth? _____
6. Are you aware of any swelling or lumps in your mouth? _____
7. When was your last dental cleaning? _____
8. Do your gums bleed when you brush or floss? _____
9. Have you ever had periodontal (gum) treatments? _____
10. Is there any unpleasant taste or odor in your mouth? _____
11. Which of the following do you use at home on a regular basis?
 Toothbrush: Hard Medium Soft Electric
 Floss Mouthwash Gum massager Oral Irrigator (water pik)
 Fluoride (other than fluoridated toothpaste) Other cleaning device _____
 Have either of your parents lost any teeth due to gum disease? Mother Father Both
12. Do you have any missing teeth? Yes No
 Have they been replaced? Yes No
 Are you comfortable with the replacements? Yes No
13. Do you have any loose teeth? Yes No
14. Have you ever had orthodontic treatment (braces)? Yes No
15. Do you lose fillings or break fillings? Yes No
16. Do you eat much citrus fruit? Yes No
17. Do you frequently drink soft drinks? (regular/ diet) Yes No
18. Do you usually have many cavities? Yes No
 Cracked or broken teeth? Yes No
19. Do you have any noticeable wear on your teeth? Yes No
 Food traps? Yes No
20. Do you grind or clench your teeth? Yes No
21. Do you have frequent headaches? Yes No
22. Do you have frequent pain in or around your ears? Yes No
23. Does your jaw hurt when you open your mouth wide, yawn or chew? Yes No
24. Do you notice any clicking or grinding noises in your jaw joint? Yes No
25. Does your jaw get “stuck,” “locked” or “go out?” Yes No
26. Does your bite feel uncomfortable or unusual? Yes No
27. Have you had any injury to your jaw, head or neck? Yes No
28. Have you ever been treated for a temporomandibular disorder? Yes No
 If so, when, what, how and by whom? _____
29. Do you like the appearance of your teeth and your smile? Yes No
 If not, what would you like to change the most in the appearance of your teeth? _____
30. Have you ever had an unpleasant dental experience or are dissatisfied with your past dentistry? _____
31. Please add anything else you feel is important.

