 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_ □ Male □ Female

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate Box □ Single □ Married □ Divorced □ Separated □ Widowed

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance**

|  |  |
| --- | --- |
| **Primary Insurance**  Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth \_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID/SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Secondary Insurance**  Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth \_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID/SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Dental History**

Previous dentist & location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any problems associated with previous dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

|  |  |  |
| --- | --- | --- |
| □ Bad Breath | □ Loose Teeth or Broken Fillings | □ Sensitivity to Sweets or Biting |
| □ Bleeding Gums | □ Orthodontic Treatment | □ Blisters on Lips or Mouth |
| □ Frequent Headaches | □ Finger Nail Biting | □ Periodontal Treatment |
| □ Jaw, Head, or Neck Injuries | □ Grinding Teeth | □ Lip or Cheek Biting |
| □ Sensitivity to Hot  □ Dry Mouth | □ Sensitivity to Cold  □ Dentures/Partials | □ Tooth Pain |

**Health History**

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the Appropriate Answer:

□ Yes □ No Are you currently under medical treatment? If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Are you taking any medications now? If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Have you had any serious illness or operations? If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Do you smoke or drink alcohol? If yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Do you need to pre-medicate for dental procedures? If yes, specify condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Do you have any allergies?

|  |  |  |  |
| --- | --- | --- | --- |
| □ Local Anesthetics | □ Penicillin | □ Latex | □ Sulfa Drugs |
| □ Aspirin | □ Iodine | □ Metals/Jewelry | □ Sedatives |
| □ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

Women Only: Are you Pregnant? □ Yes □ No Nursing? □ Yes □ No

Please check all that apply:

|  |  |  |
| --- | --- | --- |
| □ High Blood Pressure | □ Thyroid Problem | □ Chest Pains |
| □ Rheumatic Fever  □ Sinus Trouble | □ Frequently Tired  □ Severe Headache/Migraines | □ Hay Fever Allergies  □ Sleep Apnea/Snoring |
| □ Swollen Ankles | □ Anemia | □ Stroke |
| □ Fainting/Seizures | □ Emphysema | □ Tuberculosis |
| □ Asthma | □ Cancer | □ Radiation Therapy |
| □ Low Blood Pressure | □ Arthritis | □ Glaucoma |
| □ Epilepsy/Convulsions | □ Joint Replacement/Implant | □ Recent Weight Loss |
| □ Leukemia | □ AIDS or HIV Infection | □ Liver Disease |
| □ Diabetes | □ Hepatitis/Jaundice | □ Respiratory Problems |
| □ Kidney Disease  □ Eating Disorder | □ STD \_\_\_\_\_\_\_\_\_\_\_  □ Osteoporosis | □ Stomach Trouble/Ulcer  □ Reflux/Persistent heartburn |
| □ Angina | □ Heart Attack | □ Heart Disease |
| □ Heart Murmur  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Mitral Valve Prolapse | □ Cardiac Pacemaker |
|  |  |  |

Please initial if nothing is checked \_\_\_\_\_\_

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me or services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance company.

Please Print Name ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Leominster Family Dentists**

**OUR POLICIES**

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  You are responsible for knowing your dental insurance benefits!

Dental plans differ significantly. Each patient should know and understand his or her individual benefit package. Please contact your insurance company at the telephone number on your insurance card if you have questions regarding your coverage.

Patients with dental insurance are responsible for paying any co-payment, deductible, or fees for non-covered services at the time the services are rendered. We will be happy to give you an estimated treatment plan, however this is ONLY AN ESTIMATE and the patient is ultimately responsible for any payment not covered by insurance.

To help you get the most from your dental plan, we encourage you to become familiar with your insurance plan before seeking care.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian if minor Date

Authorization, Release & Agreement to pay for services rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental Care to third party payors and/or other health practitioners.

I authorize and hereby request insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s).

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment: MasterCard, Visa, Discover and American Express. For extensive services we offer low and no interest payment plans through Care Credit. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance. Payment is expected at the time services are performed.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian if minor Date

Missed and Cancelled Appointment Policy

We reserve appointment times specifically for each patient so that we may provide the ultimate care and service. Please schedule your appointment carefully as there will be a fee of $35/Hygiene, $75/Doctor to your account for any appointment missed/cancelled without 24 hours notice. Similarly, late arrivals can create scheduling problems with other patients. Please notify us if you are going to be late.

If you need to change an existing appointment, please call during our regular business hours listed below as our machines are not able to take cancellation messages. Cancellations via text messages or e-mails are also not accepted.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian if minor Date

Divorce, Separation & Custody Agreements

We believe that such matters should not enter into a child’s medical treatment. The individual who is requesting the medical treatment is totally responsible for the payment of the medical bills. We are not a party to your divorce agreement, we will collect co-pays and deductibles from the attending parent.

“Joint Custody” means that each parent has equal access to the child’s medical record. Without a COURT ORDER, we will not stop either parent from looking at their child’s chart or obtaining their child’s test results.

We will not call the other parent for consent prior to treatment.

We will discuss with the accompanying parent, information pertinent to the child’s history and/or present exam. We reserve the right to charge an administrative fee for copying records. Should the issues that come between parents become disruptive to our organization, we will take appropriate measures.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian if minor Date

**DENTAL TREATMENT CONSENT**

1. I authorize Leominster Family Dentists to perform dental treatment including local anesthesia, examination, radiographs (x-rays) or diagnostic aids.
2. In general terms, dental treatment may include but is not limited to one or a number of the following:
   * Administration of local anesthesia
   * Cleaning of the teeth and application of topical fluoride
   * Scaling and root planing with local anesthesia
   * Application of sealants to the grooves of the teeth
   * Treatment of disease or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white)
   * Stainless steel crowns for children. These are necessary in cases where a simple filling would not be the best long term restoration or in cases where there are large cavities.
   * The replacement of missing teeth with a dental prosthesis (crown, implant, partials, etc)
   * Treatment of disease or injured oral tissues (hard/or soft)
   * Treatment of malposed (crooked) teeth and/or development abnormalities
   * Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also known as “endodontic” therapy or root canal treatment

**Risks of Dental Procedures in General**

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, prolonged numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of the vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in the teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours of until recovered from their effects.

**Changes in Treatment Plan**

I understand that during treatment, it may be necessary to change and/or alter procedures because of conditions found while working on the teeth that were not discovered during examination. Upon being informed, I will give my permission to the dentist to make any/all changes and addition as necessary.

**Fillings**

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

**Crown (Caps) and Bridges**

I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept in place until the permanent crowns are delivered. I realize the final opportunity to make changes in any new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size or color will incur an additional charge.

**Alternative Treatment**

I understand that I have the right to choose on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Print Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient, Parent or Guardian**  Date

**Acknowledgement of Receipt of Notice of Privacy Practices**

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for my dental and/or account information to be discussed with the following persons:

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

* Individual refused to sign
* Communication barriers prohibited obtaining the acknowledgment
* An emergency situation prevented us from obtaining acknowledgement
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_