Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name

Sex	Marital Status	Date of Birth	Social Security Number

Patient's Address	City	State	Zip Code

Mobile Phone	Home Phone	Email

Emergency Contact Information

Emergency Contact Name	Phone Number	Relation To Patient

Referral Information

How did you hear about us?	Name of person, site, publication, etc.?

Billing & Insurance

Primary Dental Insurance (if applicable) Please note: The insured/member is the person who subscribes to the plan.

Insurance Company	Plan Name

Insured's ID	Group Number	Insured's Employer

Insured's Name	Insured's Date Of Birth	Insured's Relation To Patient

Insured's Address (If different from patient)	City	State	Zip Code

Mobile Phone	Home Phone	Email

Secondary Dental Insurance (if applicable)

Insurance Company	Plan Name

Member/Insured's ID	Group Number	Insured's Employer

Insured's Name	Insured's Date Of Birth	Insured's Relation To Patient

Medical History & Health Information

Primary Care Physician: _____ Phone: (_____) _____ - _____

Allergies

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Adhesive Tape
- ☐ Barbiturates
- ☐ Codeine
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline

Do you have any other allergies? If so, please list:

_____
_____
_____
_____

Lifestyle Factors

Do you currently smoke?

☐ No ☐ Yes, I smoke _____ packs per day.

Do you use chewing tobacco?

☐ No ☐ Yes, I use chew _____ times per day.

Do you use recreational drugs?

☐ No
☐ Yes, I use the following drugs:

_____
_____
_____
_____

Current Medications

Are you currently taking any blood thinners?

☐ No
☐ Yes, I am currently taking: _____

Do you require premedication before seeing a dentist?

☐ No
☐ Yes, I am required to take: _____

Please list any other medications and their dosages:

_____
_____
_____
_____

Women Only

Are you pregnant?

☐ No ☐ Yes, I am _____ weeks pregnant.

Are you breastfeeding?

☐ No ☐ Yes

Hospitalizations & Surgeries

_____
Reason Date

_____
Reason Date

_____
Reason Date

Past Medical History

Have you experienced any of the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint(s)
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Blood Disease
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chicken Pox / Measles
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis – A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Low Blood Pressure
- ☐ Lung Disorder
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Disorder
- ☐ Radiation Treatment
- ☐ Respiratory Disorder
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Skin Disorder/Rash
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Do you have any conditions not listed above or is there anything else you feel we should know about your medical history and information?

☐ No
☐ Yes, please note the following:

Dental History

When was your last dental exam/cleaning?
Date:_____/_____/_____

When were your last dental x-rays taken?
Date:_____/_____/_____

What are your main concerns regarding your oral health?
_____
_____
_____
_____

Have you ever had periodontal (gum) treatments?
- ☐ No
- ☐ Yes, I had periodontal treatment _____ years ago.

Have you ever had orthodontic treatment (braces)?
- ☐ No
- ☐ Yes, I had orthodontic treatment _____ years ago.

How often do you brush? _____ times / day

How often do you floss? _____ times / day

Do you have any of the following?

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Mouth
- ☐ Broken Fillings
- ☐ Clicking Jaw
- ☐ Dentures
- ☐ Difficulty opening/closing mouth
- ☐ Dry Mouth
- ☐ Difficulty Chewing
- ☐ Discolored Teeth
- ☐ Ear Pain
- ☐ Jaw Pain
- ☐ Loose Teeth
- ☐ Mouth Sores
- ☐ Sensitivity to Heat / Cold
- ☐ Sensitivity to Pressure
- ☐ Swollen Gums

FOR OFFICE USE:
Signature of reviewing provider: _____ Date: _____

Office Policies

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to refusing or consenting to treatment you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered to your satisfaction.

By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence of these risks. As with any medical procedure, no treatment carries an absolute guarantee of success or effectiveness.

It is important that to provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided and that my dentist treats to my current and specific needs regardless of past treatment/diagnosis:

- Diagnostic Services (e.g. exams, radiographs)**;** Preventative Services (e.g. prophylaxis, fluoride, sealants); Other services as diagnosed such as restorative, endodontic, prosthodontics, periodontal, and/or surgical procedures.

Patient Initials _____

2. Drugs & Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **I have disclosed any and all known allergies, medications, and conditions to my dentist to help prevent the aforementioned issues.**

Patient Initials _____

3. Changes in Treatment Plan

During treatment it may be necessary to alter planned procedures because of conditions found mid-treatment that were not discovered during examination, e.g. larger restorations than previously diagnosed, root canal therapy following restorative procedures, etc. Whenever possible I will be made aware of these changes in advance of treatment, but acknowledge this may not be possible in all instances and **hereby give permission to my dentist to make these changes as deemed necessary.**

Patient Initials _____

4. Insurance & Financial Obligation

I understand and accept that my dentist recommends and performs treatment based on my specific needs and not my insurance coverage. I hereby permit my dental office to bill my dental insurance provider for the treatment provided and for insurance payments to be made directly to my dental provider. **I understand that my dental provider and I, the patient, are bound by the terms and limitations of my insurance plan.** As my insurance company cannot guarantee any payment on any service until after the service is completed **any fees, copays, prices, etc. quoted to me by North Shore Family Dentistry are understood to be estimates only, subject to change, and are not a guarantee of insurance coverage/payment**. **I agree to pay to North Shore Family Dentistry any and all fees owed in accordance with my insurance plan.** Failure to pay any amounts owed within 60 days from date of service will result in interest charges on my account (1.5%, 18% per annum) and/or my account being transferred to a collection agency.

Patient Initials _____

5. Cancellation Policy

Your time is valuable so we try our best to keep your scheduled appointments. Our time is valuable so we request **at least 24 hours advance notice** if you cancel a scheduled appointment. **A $50.00 charge** will be assessed for any appointments broken and/or cancelled without at least 24hours notice to our office. At our discretion, repeated (e.g. 3 in a 12 month span) tardiness, broken appointments and/or cancellations may result in dismissal from our office.

Patient Initials_____

By signing below I am agreeing to all terms and conditions enclosed in the preceding pages and acknowledge that the information provided is both complete and truthful to the best of my knowledge. I understand that any electronic, facsimile, or other reproduction of this form and signature is valid and binding.

_____ _____

Patient (or Patient's Guardian) Signature Date

□ Check if you are signing as the parent/guardian of the above patient and please complete the following:

Name: _____ Phone: _____

Relation: _____ Are you the custodial parent of the patient? YES / NO

HIPAA Patient Acknowledgement of Receipt of Notice of Privacy Practices

NORTH SHORE FAMILY DENTISTRY
3 Woodland Rd. #417
Stoneham, MA 02180

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)._____

_____

_____