PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ ☐ Male ☐ Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	☐	☐	Excessive Bleeding	☐	☐	Jaundice	☐	☐	Respiratory Problems/Disorders	☐	☐
Alcoholism	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever	☐	☐
Allergies	☐	☐	Glaucoma	☐	☐	Kidney Dialysis	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Hay fever	☐	☐	Latex Sensitivity	☐	☐	Scarlet Fever	☐	☐
Arthritis	☐	☐	Head injuries	☐	☐	Lupus	☐	☐	Seizures/Fainting spells	☐	☐
Asthma	☐	☐	Hearing Impaired	☐	☐	Low Blood Pressure	☐	☐	Sinus Problems	☐	☐
Blood Disease	☐	☐	Heart Disease	☐	☐	Malignancies	☐	☐	Stomach Ulcers	☐	☐
Bone Disease	☐	☐	Heart Valve, Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Hepatitis/Liver Disease	☐	☐	Neck & Back Problems	☐	☐	Thyroid Disease	☐	☐
Chemical Dependency	☐	☐	Type(s) _____			Nervous Problems/Disorders	☐	☐	Tuberculosis	☐	☐
Chest Pain	☐	☐	Hepatitis Carrier	☐	☐	Pacemaker	☐	☐	Tumors or growths	☐	☐
Circulatory Problems	☐	☐	High Blood Pressure	☐	☐	Prosthetic Joints	☐	☐	Ulcers	☐	☐
Convulsions/Seizures	☐	☐	Hip or Joint replacement	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	HPV	☐	☐	Radiation Treatment	☐	☐			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ☐ YES ☐ No If yes, please list below:

_____

_____

Are you in good health? ☐ YES ☐ No

Date of last medical exam: _____

Have you ever been hospitalized? ☐ YES ☐ No If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ☐ YES ☐ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ☐ YES ☐ No

Have you had an allergic reaction to Bananas? ☐ YES ☐ No

Do you smoke or chew tobacco? ☐ YES ☐ No

Have you had Heart Surgery? ☐ YES ☐ No

Are you now under the care of an MD? ☐ YES ☐ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ☐ YES ☐ No

FOR WOMEN ONLY:

Are you taking birth control pills? ☐ YES ☐ No

Are you pregnant? ☐ YES ☐ No Expected delivery date: _____

Are you nursing/breastfeeding? ☐ YES ☐ No

Is there a possibility of pregnancy? ☐ YES ☐ No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date: _____

Dental History Information

Dr. Signature: _____

Date of last dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ☐ YES ☐ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ☐ YES ☐ No

Have you or a family member ever been treated for periodontal disease? ☐ YES ☐ No

Have you ever had complications from an extraction? ☐ YES ☐ No

Have you ever had a popping or clicking near your ear when you chew? ☐ YES ☐ No

Are you prone to frequent headaches? ☐ YES ☐ No

Do you grind or clench your teeth? ☐ YES ☐ No

Date: _____

Do you have sores, blisters or swelling on your gums lips or cheeks? ☐ YES ☐ No

Have you ever had orthodontic treatment? ☐ YES ☐ No

Do you snore? ☐ YES ☐ No

Do you have problems with bad breath? ☐ YES ☐ No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ☐ YES ☐ No

Have you ever used an electric toothbrush? ☐ YES ☐ No

Are your teeth sensitive to hot, cold or pressure? ☐ YES ☐ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ☐ Whiter
- ☐ Straighter
- ☐ Close space
- ☐ replace black mercury filling with tooth colored restorations
- ☐ repair chipped teeth
- ☐ replace missing teeth
- ☐ less gums showing
- ☐ replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Reviewed by: _____

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: _____ ("patient")

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

Secondary Insurance:

Secondary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ Date: _____

(to be signed even if Patient is also the Responsible Party)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Appointment Policy

Our staff at Methuen Smiles is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability and material preparation at specific times during our work day. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. Please be advised of the following requirements:

- We require 48 hours' notice for cancellation of a scheduled appointment
- A cancellation fee of $25.00 will be added for all missed or cancelled appointments with less than 24 hours' notice. Appointments longer than 60 minutes will result in a higher fee
- If there are three missed or cancelled appointments without 24 hours' notice appointments in a year time frame, we reserve the right to not schedule any further appointments or to require a deposit in order to schedule a future appointment.
- Family emergencies will be taken into consideration

_____ _____

Signature of patient (or responsible party) Date