HEALTHY SMILES DENTAL

PATIENT INFORMATION
(Confidential)

□ Mr. □ Mrs. □ Miss. □ Ms.

Last Name_____First Name_____

Home Address_____

City_____State_____Zip Code_____

Email Address_____ Home Phone Number (_____)_____

Cell Phone Number (_____)_____ Work Phone Number (_____)_____

Social Security Number _____ - _____ - _____ Date of Birth_____/_____/_____

Employer_____

Occupation_____

If Student: School/College Name_____City_____State_____

Emergency Contact_____ Phone Number (_____)_____

How did you hear about us? □ Patient (Pt. Name)_____

□ Other (Please Name) _____

INSURANCE/ACCOUNT INFORMATION

Last Name of Insured_____ First Name_____

Subscribers Social Security Number _____-____-_____Date of Birth _____/_____/_____

Relationship to Patient_____ Employer Sponsoring Plan_____

Insurance Company_____ Group #_____

Address_____City_____ State_____ Zip_____

MEDICAL HISTORY

Name of Physician: _____ Phone: (___) ___-_____ Date of last exam: ___/___/____

Do you have/ had any of the following (please check all that apply):

□ Heart problems
□ Heart murmur
□ Require pre-medication prior to dental treatment
□ High blood pressure
□ Pacemaker
□ Allergy to Penicillin
□ Latex allergy
□ Other allergies: _____
□ Asthma
□ Tuberculosis
□ Hepatitis (Type A__B__C__)
□ Diabetes
□ Dry Mouth
□ Tobacco Use
□ HIV or AIDS
□ Venereal disease
□ Artificial joints
□ Cancer
□ Epilepsy
□ Mental disorders
□ Stroke
□ Excessive bleeding
□ Glaucoma
□ Pregnant? Due date: __/__/___
□ other medical conditions:

_____
_____
_____

Please list any medications you are currently on:

_____

Have you ever had complications following dental treatment? □ Yes □ No
If yes please explain: _____

Have you been admitted to the hospital in the past two years? □ Yes □ No
If yes please explain: _____

DENTAL HISTORY

Name of previous dentist: _____ Date of last exam: ___/___/____

Do you have any of the following?

□ Sensitivity to cold or heat
□ Sensitivity to sweet
□ Sensitivity to biting
□ Pain in any of your teeth
□ Swelling in your face or mouth
□ Problems with previous dental treatment
□ Bleeding gums
□ Loose teeth

Do you like your smile? □ Yes □ No
If no please explain:

_____

Comments:_____
_____
_____

To the best of knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature: _____Date: ___/___/____
Doctor's Signature:_____Date: ___/___/____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to 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. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you 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.

- I understand that during my course of treatment that the following care may be provided:

Examinations	Bridges	Root Canal Treatment
Preventive Services	Crowns	Periodontal Treatment
Restorations	Surgery	Other

Patient Initials _____

- I understand the use of anesthetics involves certain risks including, but not limited to, temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas. 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).

Patient Initials _____

- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make changes and additions as necessary.

Patient Initials _____

- I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Initials _____

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Date

APPOINTMENT CANCELLATIONS

As a courtesy, we make every effort to confirm your appointment one day in advance. However it should be noted it is your responsibility to keep all appointments. We request a minimum of 48 hours to change or cancel an appointment. A fee will be incurred for all failed or late cancellations.

DENTAL INSURANCE

If you have insurance coverage, our staff does their best to determine a proper ***estimate*** for you. We cannot always predict the actual payments your insurance carrier will make. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

AUTHORIZATION AND RELEASE

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or health practitioners.

ADDITIONAL INFORMATION

Only a licensed dentist may perform certain procedures pursuant to 234 CMR 2.04 (15). If you have any questions concerning the licensure of the person treating you, you may request to see their license. If you have any questions concerning a specific procedure, you may request whether the procedure is one that is restricted to a licensed dentist.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____

Signature of Patient/Parent/Guardian Date