We appreciate the opportunity to provide your dental care. To serve you best and stay apprised of your pertinent information we will ask that you complete the form below periodically. Thank you in advance for your cooperation.

Patient name _____ Patient Date of Birth _____ Age _____
Gender_____ Marital status_____ cell phone_____ home phone_____
Email_____
Address_____
City_____ Zip_____

Primary Dental Insurance:

Subscriber name _____ Employer_____
Subscriber Date of Birth_____ relation to the patient _____
Insurance Carrier _____ (Blue Cross, Delta, AETNA etc)
Subscriber ID#_____ Group #_____

Secondary Dental Insurance:

Subscriber name _____ Employer_____
Subscriber Date of Birth_____ relation to the patient _____
Insurance Carrier _____ (Blue Cross, Delta, AETNA etc)
Subscriber ID#_____ Group #_____

Name of previous dentist _____ Last dental visit _____
Name of primary care physician _____ Last medical exam _____

A kind referral is *always* appreciated, whom do we thank for recommending our office to you? _____

Health Questionnaire

Please complete all sections, circle Y or N and elaborate if needed

Please list all medications _____
_____
_____
_____
_____

Are you allergic to/had adverse reactions to Novocain, penicillin or other antibiotics, sulfa drugs, barbiturates, sedatives, aspirin, acetaminophen, ibuprofen, codeine, certain metals, latex or other _____

Are you required by a physician to take an antibiotic before dental visits due to heart problems, joint replacement, etc? If so please note the reason and when this requirement was set in place. _____

Do you have any removeable appliance (partial, mouth guard, retainer etc)? _____

How often do you brush? _____ floss? _____

Are you apprehensive about dental treatment?	Y / N	Circle any that apply. *Yes, I do …*
Have you had problems with prior treatment?	Y / N	-gag easily
Are your teeth sensitive?	Y / N	-have gums that feel swollen or tender
Does food catch between your teeth?	Y / N	-wear dentures
Do you clench or grind your jaw?	Y / N	-take fluoride supplements
Do you have jaw issues or headaches in the morning?	Y / N	-have difficulty chewing/chew only on one side
Are you aware of an uncomfortable bite?	Y / N	-avoid brushing an area due to pain
Are you satisfied with appearance of your teeth?	Y / N	-notice slow healing sores in/around my mouth
Do you use tobacco products?	Y / N	-have gums that bleed easily
Do you drink alcohol? How often _____	Y / N	-have gums that bleed when flossing
Is there a history of alcohol or drug abuse?	Y / N	-feel twinges of pain when having hot food or liquids, cold food or liquids, sweets, sours

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ISSUES, CIRCLE ALL THAT APPLY?

<u>Heart</u>
- Chest pain
- Shortness of breath
- Blood pressure problem
- Heart murmur
- Heart valve problem
- Rheumatic fever
- Pacemaker
- Artificial heart valve
- Taking heart medication

<u>Blood</u>
- Abnormal bleeding
- Frequent nosebleeds
- Bruise easily
- Received transfusion
- Anemia

<u>Intestinal</u>
- Ulcers
- Weight gain or loss
- Special diet
- Constipation/Diarrhea
- Kidney or bladder problems

<u>Bone/Joint</u>
- Arthritis
- Back or neck pain
- Joint replacement
- Pins or implants
- Osteoporosis

<u>Illness or Disease</u>
- Cancer/Tumor
- Tuberculosis, Asthma or other respiratory disease
- Seizures, fainting spells or Epilepsy
- Stroke
- Persistent cough or swollen glands
- Frequent or severe headaches
- Thyroid problems
- Diabetes

Please list any disease, condition or problem not listed previously that you feel we should know about and describe:

_____

_____

Patient/Parent Signature _____

Date _____ Dentist or RDH initial _____

Today's blood pressure _____

Women only

Y / N Taking contraceptives or hormones?

Y / N Are you pregnant?

Expected delivery date _____

Y / N Are you nursing?

Notes: _____

_____

_____

_____

_____

HIPAA Consent

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We are required by law to:

Maintain the privacy of your protected health information
Give you this notice of our legal duties and privacy practices with respect to that information
Abide by the terms of our notice that is currently in effect

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information.

I give consent to Scituate Family Dental to discuss my dental and financial matters with (spouse, parent, partner, adult child – circle applicable or write in name of authorized contact) _____

Financial Policy

Scituate Family Dental requires all patients to pay for treatment on the date of service. If you are covered by dental insurance, please provide us with the information advise when changes occur. We will submit a claim but any deductible, copay and/or coinsurance payment is payable at the beginning of each visit. Although we are contracted with most insurance carriers, verification of coverage or level of coverage is not guaranteed by our staff. If you have concerns please contact your insurance provider before your treatment. Any portion not covered by the plan is the patient's responsibility. A statement will be mailed out as a courtesy; however, any unaddressed balance may result in a discontinuation of service and transfer of account to a third party.

Cancellation Policy

If you need to cancel an appointment we require 48 hours. Not providing adequate notice may result in a $45.00 charge to your account. If you will be more than 10 minutes late it may be necessary to reschedule. We also ask that apprise us of changes to your contact information so we can effectively communicate regarding appointments.

Composite Filling Acknowledgement

We offer our patients the best dental care and materials available. You are being informed that unless otherwise requested prior to a filling being done, composite (white) material is used. If you wish to have an amalgam (silver) restoration, please inform the doctor at the time treatment is provided. I understand and agree that I am responsible for the difference between composite and amalgam fillings regardless of insurance benefits.

My signature below acknowledges and accepts the policies of Scituate Family Dental as outlined above.

PATIENT PRINTED NAME:_____ SIGNATURE: _____

If signing for patient, your relationship to the patient: _____DATE:_____

We are grateful you have chosen Scituate Family Dental! Our team values the opportunity to provide you with the best comprehensive dental care possible and we appreciate your kind referrals!

~ THANK YOU!