NEW PATIENT INFORMATION

PATIENT NAME

Last First MI Preferred Name

TITLE: _____ GENDER: ☐ Male ☐ Female FAMILY STATUS: ☐ Married ☐ Single ☐ Child ☐ Other

BIRTH DATE SOCIAL SECURITY NUMBER PREVIOUS VISIT

EMAIL ADDRESS BEST TIME TO CALL

PHONE Home Mobile Work Ext Fax Other

ADDRESS

City State Zip Code

EMPLOYMENT

The following is for: ☐ the patient ☐ the person responsible for payment ☐ both ☐ not applicable

Employer Name Phone

Employer Address

City State Zip Code

I prefer to be contacted by ☐ Cell Phone ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

In an emergency, who should be notified? Please enter name, phone number and relationship below

LOWELL DENTAL ARTS
FAMILY DENTISTRY

1 RIVER PLACE LOWELL, MA 01852 | LOWELLDENTALARTS@GMAIL.COM | 978-458-1114 | 978-770-0919

DENTAL INFORMATION

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name _____ Phone Number _____

Approximate date of most recent dental exam and/or dental x-rays _____

I routinely see a dentist every ☐ 3 mos ☐ 4 mos ☐ 6 mos ☐ 12 mos ☐ Not routinely

What is your immediate concern about your dental health?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

CHECK ALL THAT APPLY

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/Have braces or orthodontic treatment
- ☐ Experiences dry mouth
- ☐ Sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Whitened or bleached your teeth
- ☐ Experienced popping and/or clicking of your jaw joint
- ☐ Difficulty chewing
- ☐ Clenching or grinding of teeth
- ☐ Currently or previously wore a bite appliance
- ☐ Wears removable partial/denture
- ☐ Gums bleed when brushing or flossing
- ☐ Diagnosed and/or treated for gum disease
- ☐ Bone loss around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ Snores or wakes up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

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CONSENT FOR SERVICES AND FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with denial insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from Insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment Is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

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HIPAA ACKNOWLEDGMENT

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

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CANCELLATION AND NO SHOW POLICY

Our office values your time and takes great effort to stay on schedule to see you at the time of your scheduled appointment. We feel our time is just as valuable so we request a 48-hour notice for all cancelled appointments.

_____ If we do not receive a 48-hour cancellation notice for your scheduled hygiene appointment, we will charge a $30.00 cancellation fee.

Initial

_____ If we do not receive a 48-hour cancellation notice for your scheduled doctor's appointment, we will charge a $50.00 cancellation fee.

Initial

You will be directly responsible for payment of the cancellation or no show fee. This fee cannot be billed to your insurance company.

We will continue to use all efforts to confirm your appointments by phone and also by postcard for your six-month hygiene appointments.

We appreciate your cooperation and understanding.

Signature of Patient or Guarantor Date

Signature Date

_____

Response Date

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MEDICAL HISTORY

PATIENT NAME

Last First MI Preferred Name

Indicate which of the following you have had or have at present By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *PREMED-Amax
- ☐ *PREMED-Other
- ☐ Allergy-Hay Fever
- ☐ Allergy-Other
- ☐ Anxiety
- ☐ Blood Disease
- ☐ Cancer
- ☐ Glaucoma
- ☐ Heart MVP
- ☐ Kidney Disease
- ☐ Medication-Dilantin
- ☐ Pacemaker/Stents
- ☐ Respiratory Problems
- ☐ STD/HPV
- ☐ Thyroid Disorder
- ☐ *PREMED-Cinda
- ☐ Allergy-Aspirin
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Arthritis
- ☐ Blood Pressure-High
- ☐ Diabetes
- ☐ Heart Attack/Stroke
- ☐ Hepatitis A, B, or C
- ☐ Liver Disease
- ☐ NO EPI
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Steriodal Medication
- ☐ Tumors/Growths
- ☐ *PREMED-Elythro
- ☐ Allergy-Codeine
- ☐ Allergy-Metals
- ☐ Allergy-Sulfa
- ☐ Artificial Prosth
- ☐ Blood Pressure-Low
- ☐ Dry Mouth
- ☐ Heart Disease
- ☐ HIV-Pos/AIDS
- ☐ Med-Birth Control
- ☐ Other Medications
- ☐ Psychiatric Care
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ *PREMED-Keflex
- ☐ Allergy-Erythro
- ☐ Allergy-N-Saids
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Epilepsy/ Seizures
- ☐ Heart Murmur
- ☐ Immunosupressed
- ☐ Medication for BP
- ☐ Other
- ☐ Radiation/Chemo
- ☐ Sinus Problems
- ☐ TB

- ☐ No medical conditions
- ☐ Presently being treated for any other illness
- ☐ Taking birth control
- ☐ Recent hospitalization (illness or injury)
- ☐ Tobacco/Alcohol Use
- ☐ Diagnosed with Osteoporosis
- ☐ Subject to frequent headaches or migraines
- ☐ Pregnant/Planning Pregnancy/ Nursing

If any conditions or alerts selected needs further clarification, please describe below.

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Do you take antibiotic premedication for your dental visits? If yes, please explain.

List all medications (prescription and non-prescription) including regular dosages of aspirin

Please list any allergies and/or allergies to medications.

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Name of physician and date of last physical exam

☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

PATIENT/PARENT OR GUARDIAN COMPLETING THIS FORM

Signature Date

Response Date

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