

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: _____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo #

City State Zip

Single Married Partnered Divorced/Separated Widowed

Hm #: _____ Cell #: _____

Wk #: _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: _____ Ext: _____ SS #: _____

Birthdate: _____ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name: _____ Relation: _____

Wk #: _____ Hm #: _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Payment is due in full at the time of treatment

unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

CONTINUED ON BACK

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one:

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |

Please list any other drugs/materials that you are allergic to: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Patient Signature Date

Dentist Signature Date

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Patient Signature Date

Dentist Signature Date

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DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

Have you ever had gum treatment? Yes No

Do your gums ever bleed? Yes No Ever Itch? Yes No

Have you ever had periodontal disease? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? Yes No

Do you still have wisdom teeth? Yes No

Would you like fresher breath? Yes No Whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____



Failla & DeFrancesco Family Dentistry

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Waltham, MA 02451
(781) 894-3143

293 Mt Auburn St
Watertown, MA 02472
(617) 923-9446

The treatment recommended by our office is never based on what your insurance company will pay; your health care should not be governed by your insurance contract. It should be understood that the dental insurance is a contract between the insurance company and the patient, whom bears the ultimate financial responsibility.

As of February 1, 2017, our office is currently In-Network with the following insurance plans:

- Blue Cross Blue Shield of Massachusetts- Indemnity plan
- Delta Dental- PPO & Premier Plans
- Cigna- Dental PPO
- Guardian
- Altus

If you have an insurance plan which is Out-of-Network (such as Metlife or Aetna), please check with your insurance provider to verify your coverage of services at our office. We DO accept other insurances, but your plan must allow for Out-of-Network coverage.

Starting January 1, 2013, any submitted insurance claims not paid by your insurance company within 30 days of submission will become the patient's full responsibility. Any contact with the insurance company regarding these claims will also become the responsibility of the patient. Any balances on an account that are outstanding for over 90 days will be sent to an outside agency for collection.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Patient Name: _____

Date: _____

Signature: _____

Relationship to Patient (if applicable): _____

*****PLEASE SEE THE REVERSE SIDE OF THIS PAGE*****

HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment for third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review upon my request of such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that my information may be transmitted electronically and may not be encrypted. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient (please print): _____ **Patient 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 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.

1. Treatment to Be Provided

I understand that during my course of treatment that the following care may be provided: Examination, Preventative services, Restorations, Crowns, Bridges, and Other Treatment

2. Drugs and 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).

3. Dental Filling Material

I understand that the use of composite resin (tooth colored) material on back teeth may result in a reduction of insurance benefits. Amalgam (silver mercury) fillings are no longer used in our office.

4. Changes in Treatment Plan

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 examinations, the most common being root canal therapy following routine restorative procedures. You will be informed of any changes to your treatment plan.

5. Responsibility of Payment

I understand that I am responsible for knowing my contract with my insurance company and that any claims not paid by my insurance company are my full financial responsibility. I understand that any balances may be shared with my spouse and/or parental guardian unless I have specifically requested them not to be.

Patient (please print): _____ **Patient Signature:** _____

Date: _____