

DATE _____

PATIENT INFORMATION

PLEASE PRINT

PATIENT'S NAME <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms.	DATE OF BIRTH	AGE	SOCIAL SECURITY #
ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY	CITY and STATE	ZIP CODE	HOME PHONE #
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF A STUDENT)	HOW LONG EMPLOYED	BUS. PHONE #
EMPLOYERS STREET ADDRESS	CITY and STATE	ZIP CODE	
SPOUSE or PARENT'S NAME	# OF CHILDREN and AGES	PHONE #	
ADDRESS	CITY and STATE	ZIP CODE	

Who referred you to us? _____

In the following questions, check no or yes, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year? No Yes
2. When was your last physical examination? _____
3. Are you now under the care of a physician? No Yes
If so, what is the condition being treated? _____
4. The name of my physician is _____
Address _____
Phone # _____
5. Have you had any serious illness or operation? No Yes
If so, what was the illness or operation? _____
6. Have you been hospitalized or had a serious illness within the past five (5) years? No Yes
If so, what was the problem? _____
7. Are you taking any drug or medicine? No Yes
If so, what? _____
8. Do you or have you smoked or used tobacco products? No Yes
If so, what and how often? _____
9. Do you have or have you had any of the following diseases or problems?
 - a. Rheumatic fever or rheumatic heart disease No Yes
 - b. Congenital heart lesions, heart murmur No Yes
 - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) No Yes
 - 1) Do you have pain in chest upon exertion? No Yes
 - 2) Are you ever short of breath after mild exercise? No Yes
 - 3) Do your ankles swell? No Yes

Continued on next page

4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?

No Yes

d. Allergies

No Yes

If so, specify _____

e. Sinus trouble

No Yes

f. Asthma or hay fever

No Yes

g. Hives or a skin rash

No Yes

h. Fainting spells or seizures

No Yes

i. Diabetes

No Yes

If yes, do you take insulin?

No Yes

j. Hepatitis, jaundice or liver disease

No Yes

k. Arthritis

No Yes

l. Inflammatory rheumatism (painful swollen joints)

No Yes

m. Stomach ulcers

No Yes

n. Kidney trouble

No Yes

o. Tuberculosis

No Yes

p. Do you have a persistent cough or cough up blood?

No Yes

q. Low blood pressure

No Yes

r. Venereal disease (Herpes, Syphilis, Gonorrhea)

No Yes

s. AIDS, ARC, HTL Virus

No Yes

t. Prosthetic replacements (Hip, Knee, Valve, etc.)

No Yes

u. Alcoholism or substance abuse

No Yes

10. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?

No Yes

a. Do you bruise easily?

No Yes

b. Do wounds tend to heal slowly?

No Yes

c. Have you ever required a blood transfusion?

No Yes

If so, explain the circumstances _____

11. Do you have any blood disorder such as anemia?

No Yes

12. Are you presently dieting?

No Yes

If for medical reasons, please specify _____

13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips?

No Yes

14. Are you taking any of the following:

Check applicable box

Antibiotics or sulfa drugs

Aspirin

Anticoagulants (blood thinners)

Insulin, tolbutamide (Orinase) or similar drug

Medicine for high blood pressure

Digitalis or drugs for heart trouble

Cortisone (steroids)

Nitroglycerin

Tranquilizers

Anti depressants, MAO inhibitors

Antihistamines

Other

15. Are you allergic or have you reacted adversely to:

- Local anesthetics
- Penicillin or other antibiotics
- Sulfadrugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Iodine
- Other _____

16. Have you had any serious trouble associated with any previous dental treatment? No Yes

If so, explain _____

17. Do you have any disease, condition, or problem not listed above that you think I should know about? No Yes

If so, please explain _____

18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? No Yes

19. Are you wearing contact lenses? No Yes

WOMEN

20. Are you pregnant? No Yes

21. Do you have any problems associated with your menstrual period? No Yes

22. DENTAL HISTORY

a. When was your last Dental visit _____

b. Do you have pain in or near your ears? No Yes

c. Do you have unhealed injuries or inflamed areas in or near mouth? No Yes

d. Have you ever had growths or long-term sores in your mouth? No Yes

e. Does your mouth or teeth hurt when you clench your teeth? No Yes

f. Do you have a habit of grinding or clenching your teeth? No Yes

g. Have you had local anesthetics before? No Yes

(explain any problems) _____

h. Do you have special problems or concerns about your teeth? No Yes

Comment: _____

i. Are your teeth sensitive to heat, cold, sweets? No Yes

j. Are you nervous about having dental treatment? No Yes

Comment: _____

k. When were your last dental X-Rays (explain) _____

l. Who was your previous Dentist _____ Phone # _____

Your signature below means you understand all of the above questions and have answered them to the best of your ability.

Signature (parent or guardian, if patient is under 18) _____ Date _____

INSURANCE INFORMATION

NAME OF EMPLOYER	I.D./SOC. SEC. #	GROUP/POLICY #
NAME OF INSURANCE CO.	INSURANCE PHONE #	EFFECTIVE DATE
NAME OF INSURED	D.O.B. OF INSURED	
SECONDARY INSURANCE CO.	I.D./SOC. SEC. #	
NAME OF EMPLOYER	EFFECTIVE DATE	GROUP/POLICY #
NAME OF INSURED	D.O.B. ON INSURED	

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON)

Doctor's Remarks

Southborough Dental Associates

11 Main Street
Southborough, MA 01772
508-481-6100
contactus@southboroughdental.com

CONSENT FOR TREATMENT

Patient's Name: _____ Birthdate: _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the Southborough Dental Associates. These procedures include, but are not limited to; examinations, oral prophylaxis, radiographs, fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal treatments, endodontic treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Payment and Insurance Policies:

Payment is due when services are rendered. We accept cash, checks, Discover, Visa and MasterCard. When there are complex or extended treatment plans our financial coordinators are available to discuss flexible financing options through Care Credit.

Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract, but will be happy to assist you in the processing of your insurance claims. Please be aware that your insurance may only partially cover services provided, if at all, and coverage varies among insurance companies and employers. Payment of your annual deductible and estimated co-pay is required at date of service. It is your responsibility to notify us of any changes, or termination of your insurance coverage. By signing this form, you authorize payment directly to our office that is otherwise payable to you.

Please note: Because of the difficulty in billing a third party, the parent who brings the child in for his/her care will be financially responsible for all treatment cost.

General Information:

A fee of \$60.00 will be charged for any missed appointments and appointments cancelled without at least 24 hours notice. All checks returned to this office will be subject to a \$25.00 charge which will be added to the patient's account.

Patient's Signature: _____ Witness: _____ Date: _____

Parent or Guardian Signature: _____ Relationship: _____

(For children under the age of 18)

Please initial acknowledging that our Notice of Privacy Practices was made available to you.

Initials: _____

