STOUGHTON DENTISTRY

PATIENT INFORMATION

Patient Last Name: ______________________ First: ___________________ MI ______
Preferred Name: ___________________Sex: _____M _____F Birth Date: ________
Marital Status: ________________ Social Security No.: ___________________________
Street Address: ____
City: __________________________ State: _______ Zip: _______________
Home Phone: __________________ Work: ___________________
Cell: ___________________ Email: ___________________
Preferred Contact Method: ____ Home ____ Work ____ Cell ____ Email
Whom may we thank for referring you to our practice?
____

INSURANCE INFORMATION

Subscriber Last Name: ___________________________ First: _________________ MI ______
Birth Date: _________________ Is Subscriber a patient? ____ Y ____ N
Subscriber SS No.: ____________________ Subscriber ID: _______________________
Subscriber Street Address (if different): ____
City: _______________________ State: ______ Zip: _______________
Subscriber's relationship to patient: ____ Self ____ Spouse ____Child Other _____
Employer's Name: ________________________________ Group No.: ______________________
Employer's Street Address: _______________________________________
City: ___________________________ State: _______ Zip: ___________________
Insurance Plan Name: ____________________________ Subscriber ID: ________________
Insurance Street Address: ____
City: ___________________________ State: _______ Zip: ___________________
Insurance Phone: __________________________________
Is Patient covered by additional dental insurance? ____ Y ____ N
(If Yes, please complete additional insurance information below)
Dependent Student Status: ____________________ Name of School: _________________
____ Full Time ____ Part Time
Names of other dependents covered under this plan:
____

ADDITIONAL INSURANCE INFORMATION

Subscriber Last Name: _________________________ First: _________________ MI ______
Birth Date: _________________ Is Subscriber a patient? ____ Y ____ N
Subscriber SS No.: ____________________ Subscriber ID: _______________________
Subscriber Street Address (if different): ____
City: _______________________ State: ______ Zip: _______________
Subscriber's relationship to patient: ____ Self ____ Spouse ____Child Other _____
Employer's Name: _________________________________ Group No.: __________________
Employer's Street Address: _______________________________________
City: ___________________________ State: _______ Zip: ___________________
Insurance Plan Name: _____________________________ Subscriber ID: _______________
Insurance Street Address: ____
City: ___________________________ State: _______ Zip: ___________________
Insurance Phone: __________________________________
Dependent Student Status: ____________________ Name of School: _________________
____ Full Time ____ Part Time
Names of other dependents covered under this plan:
____

STOUGHTON DENTISTRY

HEALTH HISTORY

Physician's Name: ____

Street Address: ____

City: _______________________ State: ______ Zip: ______________

Phone: ____________________________ Date of last exam: ____________________

Are you currently being treated by a physician? ☐ Y ☐ N

If yes, please explain: ____

Have you been admitted to a hospital or had emergency care in the past two years? ☐ Y ☐ N

If yes, please explain: ____

Are you currently taking any medications, including oral contraceptives or aspirin?

☐ Y ☐ N If yes, please list: ____

Have you had an allergic reaction? ☐ Y ☐ N

If yes, please list all allergies: ____

Have you ever had Botox or fillers? ☐ Y ☐ N

Do you or have you used tobacco products? ☐ Y ☐ N

For how long? ____

Do you consume alcoholic beverages? ☐ Y ☐ N

How often? ____

Do you have any history of the following diseases or conditions?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding (prolonged)
- ☐ Brain injury
- ☐ Cancer: Type ___________________
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Diabetes
- ☐ Emotional disability
- ☐ Fainting
- ☐ Gastrointestinal Disorders
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Infections (AIDS)
- ☐ Jaundice
- ☐ Lyme Disease
- ☐ Intellectual Disability
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Rheumatic Fever
- ☐ Transfusion of Blood
- ☐ Scoliosis
- ☐ Sickle Cell Trait/Disease
- ☐ Stroke
- ☐ Syndrome: Type _________________
- ☐ Thyroid Condition
- ☐ Other

Women: Are you Pregnant? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctors and staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Signature: ____ **Date:** _________________

Print Name: ____

STOUGHTON DENTISTRY

DENTAL HISTORY

Reason for today's visit:

____

Date of last dental visit: ____________________ Were X-rays taken? ____ Y ____ N

Former Dentist's Name: ____

Street Address: ____

City: ___________________________ State: ________ Zip: _______________

Phone: ________________________

Check (√) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________________________________

How often do you brush? ______________________________________

Are you happy with your smile? ____ Y ____ N

If no, please explain:

____

Do you have severe anxiety about dental treatment? ____ Y ____ N

Have you ever had an adverse reaction to dental treatment? ____ Y ____ N

If yes, please explain:

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctors and staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Signature: ____ **Date:** __________________

Print Name: ____

STOUGHTON DENTISTRY

CONSENT FOR TREATMENT, INSURANCE PAYMENT AUTHORIZATION AND FINANCIAL POLICY DISCLOSURE

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third-party of insurer to my provider. If I have insurance, I agree to make a payment of my estimated co-payment at the time services are rendered. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility. Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances. This office will help prepare insurance forms and assist in making collections from insurance companies; however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account. If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge a fee for appointments missed or canceled with less than 24 hours advance notice. This office reserves the right to charge interest of APR=12% for overdue balances. In consideration for the professional services rendered to me by Stoughton Dentistry, I agree to pay the reasonable value of said services to the Doctor or his assignee, at the time services are rendered or within 15 days of billing if credit is extended. 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 agree to pay all costs of collection, including attorney's fee and expenses, incurred to collect any unpaid fees.

Signature: ____________________________________ Date: _________________

STOUGHTON DENTISTRY

35 Park Street
Stoughton, MA 02072
Phone: 781-344-9512
Fax: 781-344-5161
office@stoughtondentistry.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I have received a copy of the Notice of Privacy Practices of Stoughton Dentistry. I hereby authorize, as indicated by my signature below, Stoughton Dentistry to use and disclose my identifying health information in unencrypted electronic format when applicable and necessary for any clinical, financial and insurance purpose.

Print Name: ____________________ **Address:** ___________________________________

Signature: ___________________________________ **Date:** ____________________

Please check your preferred means of communication:

- You may contact me at my home telephone number _________________
- You may contact me on my mobile telephone number _______________
- You may contact me on my work telephone number _________________
- You may send me an email at __________________________________
- You may leave detailed messages on voicemail of above numbers, regarding x-ray results and/or appointment needs.

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ________________________________ Date Added/Removed: _____________
2. ________________________________ Date Added/Removed: _____________
3. ________________________________ Date Added/Removed: _____________
4. ________________________________ Date Added/Removed: _____________

*****For Office Use Only:*****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify)

  ____

- STAFF INITIALS ___________