South Shore DENTISTRY
Comprehensive. Compassionate. Convenient.

WELCOME!

Patient Information

Patient Name_____MI____Preferred Name_____

Gender_____ Social Security # _____Birth Date_____

Family Status Single Married Divorced Child Partner

Phone (Home)_____ Work_____Cell_____

Email address_____

Adress_____Apt #_____

City_____ State_____ Zip Code_____

Emergency Contact Information

Name_____ Phone_____

Referral Information

Whom may we thank for referring you to out practice? (Patient, Relative, Facebook, Website, Doctor, Google, Other)_____

Dental Insurance Information

Primary Dental Insurance

Name of Insured_____

Is Insured a Patient Yes / No Insured's Birth Date_____Relationship to patient_____

Insured's Address_____

Insured's Employer Name_____

Name of Insurance_____

ID #_____Group #_____

Insurance & Phone Number_____

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Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients are responsible for all the balances regardless of having dental insurance or not. Returned checks are subject to a returned check fee.

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Patients with insurance understand that insurance may not cover your appointment cost and are solely responsible for its payment in full. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such 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. Balances over thirty (30) days become the sole responsibility of the patient, even if insurance benefits are expected, and are subject to finance charges. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of four months from the date estimate is made.

I am aware the office requires two full business days' notice for any changes in schedule. Those not following this policy will be subject to a cancellation fee.

If I have dental insurance I give permission for the office to submit for payment on my behalf.

I give permission to discuss my account with the responsible party and other necessary professionals.

I have read the above conditions of treatment & payment and agree to their content.

Patient Name _____

Signature _____ **Date** _____

Signature of guarantor of payment/ responsible party _____

Relationship to Patient _____

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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 treatment, or the option of no treatment.

Do not consent to treatment unless and until 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, referral 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 my course of treatment may require multiple examinations or procedures. It could include, but is not limited to, hygienist/dentist examinations, preventive services, periodontal care (gum care), and restorative treatment (fillings), crowns (caps), and implant or bridge treatment (to replace missing teeth).

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. 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 initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. Billing

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Print Patient Name _____

Patient Signature _____ **Date** _____

Patient Name _____ **Date** _____

Emergency Contact _____ **Phone ( )** _____
Relationship _____

Health Information

Physician Name _____ **Location/Town** _____ **Phone** _____

Date of Last visit to Physician: _____

Pharmacy _____ **Address/Town** _____ **Phone** _____

Do you currently have or ever had any of the following? Please check those that apply:

- ☐ AIDS/ HIV
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
  Last time & reason
  _____
- ☐ Auto Immune Diseases
- ☐ Blood Disease
- ☐ Blood Pressure
  High or Low
- ☐ Cancer Type
  _____
  Date: _____
- ☐ Cholesterol
- ☐ Depression/ Anxiety
- ☐ Diabetes Type I or II
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/ Seizures
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
  Type _____
- ☐ Herpes/ Cold Sores
- ☐ Jaundice
- ☐ Joint Replacement
  Date: _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Conditions
- ☐ Migraines
- ☐ Pacemaker
- ☐ Radiation Treatment
  Date _____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sinus Problems
- ☐ Sleep Disorder
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles/ Feet
- ☐ Thyroid Disorder
  Hyper or Hypo
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers/ Reflux
- ☐ Vision Issues

<u>WOMEN ONLY</u>:

- ☐ Pregnant ___ # weeks
- ☐ Nursing
- ☐ Taking Birth Control

Are you currently being treated by a physician? YES NO

If yes, please explain _____

Have you had any serious illness, recent hospitalizations or surgeries in the last 5 years? YES NO

If yes, please explain _____

Do you have any health problems that need further clarification? YES NO

If yes, please explain _____

Do you use Tobacco? YES NO How much per Day? _____

Do you use controlled substances? YES NO Type _____ **How often?** _____

<u>ALLERGIES:</u>

(Seasonal/Drug)

- ☐ Penicillin
- ☐ Aspirin
- ☐ Latex
- ☐ Codeine
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Dental Anesthetics
- ☐ OTHER: _____

_____

<u>MEDICATIONS</u> - Prescribed & Over the counter

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Name _____ **Date** _____

Dental History

Does Dental treatment make you nervous? YES NO Explain _____

What do you fear most about going to the dentist? _____

Have you ever had a bad reaction after a dental procedure? YES NO Explain _____

When was your last visit to the dentist and what was it for? _____

How often do you brush? _____ Manual OR power brush? How often do you floss? _____

Have you or do you have any of the following:

☐ Bad Taste	☐ Dry Mouth	☐ Sensitivity to Cold	
☐ Bite your cheek	☐ Gag Easily	☐ Sensitivity to Hot	List Others
☐ Bite your lip	☐ Gum Treatments	☐ Sensitivity to Sweets	☐ _____
☐ Bleeding Gums	☐ Grind Teeth	☐ Serious injury to the	☐ _____
☐ Broken Teeth	☐ Jaw Pain	mouth	☐ _____
☐ Cold Sores	☐ Mouth Odors	☐ Use a night Guard	☐ _____
☐ Clicking Jaw	☐ Orthodontic	☐ Use a Sports Guard	
☐ Dentures or Partials	Treatment		

Please answer the following questions by circling the option that best fits for you

1) My mouth is...
   a) Very Comfortable
   b) Moderately Comfortable
   c) Uncomfortable
2) I...
   a) Think the appearance of my mouth is excellent
   b) Am satisfied with the appearance of my mouth
   c) Am dissatisfied with the appearance of my mouth
3) I...
   a) Will do anything needed to keep my natural teeth
   b) Want to keep my natural teeth, but I have a certain budget of time and money I am willing to spend on them
   c) Do not care whether or not I keep my natural teeth
4) I...
   a) Have set goals for my oral health
   b) Want to set goals for my oral health
   c) Never set goals for my oral health nor want to
5) I tend to...
   a) Put dentistry for myself and my family high on the priority list
   b) Put dentistry for myself and my family low on the priority list
   c) Put it on my list but rarely get to it
6) I have...
   a) Always done what was recommended for my dental health
   b) Not always done what was recommended for my dental health
   c) Rarely done what was recommended and do not care to have my dental work completed
7) My state of dental health is...
   a) Excellent
   b) Good
   c) Poor
8) I aspire to have a mouth that is in...
   a) Excellent health
   b) Good health
   c) Poor health
9) I would like to address..... at my appointment today _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform South Shore Dentistry at the next appointment without fail.

Signature _____ **Date** _____

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Cancellation Policy

We greatly respect your time and make every effort possible to keep you from waiting. To achieve this, we schedule our time according to the amount needed to serve you and do not participate in overbooking. In order to do this, we must have your respect for our time; therefore we do have a cancellation policy regarding scheduled appointments.

When a patient misses an appointment, staff sits idle. Finding someone to fill this open time is not always possible. This unnecessarily increases the cost of dental treatment. We believe you would rather invest our resources more efficiently to treat you.

Keeping that in mind, we require a minimum of **2 business days notice** to cancel or reschedule an appointment. This notice needs to be given during regular office hours to ensure that you do not incur a charge for that appointment. We are unable to accept voice messages to cancel appointments. Our hours are: Monday & Tuesday 8:00am to 5:00pm, Wednesday 8:00am to 4:30pm, Thursday 7:00am to 6:00pm, and Friday 9:00am to 4:00pm. Our ultimate goal is to serve another patient during that time and not to charge you.

The fees for missed or cancelled appointments that do not adhere to the above guidelines are as follows:

Hygiene visit $125/ per appointment

Doctor visit $150/ per hour

Unfortunately, your insurance will not cover these charges so please help us help you not to receive a charge for a missed appointment by following these guidelines. Thank you.

I, _____, have read and understand South Shore Dentistry's cancellation policy. I also understand that a copy of this policy will be provided to me if I ask for it.

Print Patient Name _____

Patient Signature _____ **Date** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____