

PATIENT NAME _____

DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

- Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

- Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Milk [] Other _____
Women (Please check): [] Pregnant/trying to get pregnant [] Nursing [] Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Table with 4 columns of conditions (Yes/No) and 4 columns of medicines (Yes/No). Conditions include Heart Disease/Surgery*, Heart Murmur or Defect*, Irregular Heart Beat, Angina/Chest Pain, Heart Attack/Failure, Congenital Heart Disorder*, Mitral Valve Prolapse*, Scarlet Fever, Rheumatic Fever*, Artificial Heart Valve*, Heart Pace Maker*, Pulmonary Shunt*, High Blood Pressure, Low Blood Pressure, Bacterial Endocarditis*, Unexplained Fever, Bruise Easily/Blood Disease, Anemia, Coronary Stent*, Excessive Bleeding, Sickle Cell Disease, Hemophilia, Methemoglobinemia, Leukemia, Recent Blood Transfusion, Swelling of Limbs, Lung Disease, Breathing Problem, Shortness of Breath, Frequent Cough, Hay Fever, Sinus Trouble, Asthma, Bloody Sputum, Emphysema, Tuberculosis, Cancer, X-Ray Treatments (Radiation), Chemotherapy, Osteoporosis, Bisphosphonates, Osteonecrosis of Jaw, Aredia I.V. Reclast I.V., Zometa I.V., Fosamax, Actonel, Boniva, Stomach/Intestinal Disease, Ulcers, Recent Weight Loss, Frequent Diarrhea, Diabetes, Excessive Thirst, Hypoglycemia, Liver Disease, Hepatitis A (Infectious), Hepatitis B or C, Protease Inhibitor, Night Sweats, Yellow Jaundice, Kidney Problems, Renal Dialysis, Thyroid Disease, Parathyroid Disease, Arthritis/Gout, Rheumatism, Pain in Jaw Joints, Cortisone Medicine, Artificial Joint*, Sexually Transmitted Disease, AIDS, HIV Positive, Genital Herpes, Drug Addiction/Alcoholism, Tattoos/Body Piercing, Sleep Apnea, Cold Sores, Fever Blisters, Herpes, Stroke, Convulsions, Epilepsy or Seizures, Fainting or Dizziness, Glaucoma, Tumors or Growths, Nervousness, Psychiatric Care, Alzheimer's Disease, Allergies (Medicines), Allergies (Pollen / Dust), Hives or Rash, Need Premedication?, Ever taken fen-phen?*, Cochlear implants?*

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Rows for tracking updates with 'None' and checkboxes.

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
 ADULTS - COMPLETE PRIMARY INSURED
 DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you to our office?

METHOD OF PAYMENT

Responsible party currently has an account with this office

Yes No

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy

AUTHORIZATION

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 the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
 Patient or Responsible Party

 Date State Driver's License #

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Jay M. Epstein, DMD, P.C.
295 Western Avenue
Lynn, MA 01904
781-598-2100

FINANCIAL POLICY

We offer high quality dental care to all of our patients, regardless of financial status or insurance coverage. We do, however, have a financial policy that each patient must read, understand and agree to.

Non-Insurance

Payment at the time of treatment is expected to keep our billing costs down; this also enables us to continue charging competitive fees to our patients. For patients receiving extensive treatment, it is our pleasure to work out a payment plan that is mutually convenient for both the office and our patients. We accept cash, personal checks, and the following credit cards: Mastercard, Visa, Discover, American Express and CareCredit. Please take a few moments to fill out a short application for the CareCredit card. It can be processed within a few minutes. Our front desk staff can provide you with the necessary information.

Insurance

Our office is happy to cooperate with patients that are covered by dental insurance. We ask that you read the policy thoroughly to ensure your understanding of any limitations concerning benefits provided.

As a service to our patients, we will gladly process and submit all forms pertaining to your dental plan but please do not ask us to falsify insurance documents in any way. Additionally, we make no guarantee of estimated coverage.

Because an insurance policy is an agreement between you and your insurance carrier, we ask that all patients accept full responsibility for all charges. Most plans pay a portion of your fee, except for preventative and diagnostic services. Whenever co-payments apply, we ask that they be paid at the time of treatment.

If you have any questions regarding our financial policy, please do not hesitate to ask for clarification. Our staff is always happy to assist you in any way we can.

I have read the above policies and agree to abide by them.

Patient Signature

Date

HIPAA -- Health Insurance Portability and Accountability Act of 1996

I understand that, under Health Insurance Portability and 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 from 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 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 or disclosed to carry out treatment, payment or health care operations. 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 I may revoke this consent in writing at any time, except to the extent that you have taken relying on this consent.

Patient name: _____

Signature: _____

Relationship to patient: _____

Date: _____

Informed Consent
Permission for Dental Examination and/or
Treatment

I _____ do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Epstein and his associates, staff members, or agents, as he may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

Patient Signature _____ Date _____

Witness _____