



Patient History

Patient Name _____ Today's date _____ Email address _____
Address: _____ City: _____ State: _____
Zip _____ How long at this address: _____ Birth date: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Social Security Number or Insurance Identification Number: _____
If patient is a minor, give parent's or guardian's name: _____
Employer: _____ Occupation: _____
Spouse Name: _____ Spouse Birth date: _____
Spouse Employer: _____ Spouse Occupation: _____
Spouse Social Security Number or Insurance Identification Number: _____
Whom can we thank for referring you to our office? _____

Responsible Party/Billing Information

Responsible Party Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Work Phone: _____ Cell Phone: _____
Relationship to Patient: _____ Date of Birth: _____
Employer: _____ Occupation: _____
Social Security Number or Insurance Identification Number: _____

Insurance Information

Insured's Name: _____ Insured's Date of Birth: _____
Social Security Number: _____ Insurance Company: _____
Group Number: _____ Insurance Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Do you have dual insurance coverage? Yes No
If yes, Secondary Insured's Name: _____ Insured's Birth date: _____
Social Security Number: _____ Insurance Company: _____
Group Number: _____ Insurance Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Medical History

Who is your primary care physician? _____ Physician's phone# _____

How would you describe your overall health? _____ Date of last physical _____ + _____

Have you been hospitalized under a physicians care in the last two years? Yes No

Have you had an adverse reaction or allergies to any medication or substance?

(Please check if allergic)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Clindomycin-Is it Pill or IV | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Xylocaine |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa Drugs | |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Novocain or other dental anesthesia | |

Have you ever had any of the following? (Please check all that applies)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Valve or Pacemaker |
| <input type="checkbox"/> Bleeding Problem or Anemia | <input type="checkbox"/> Hepatitis (A) |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis (B) |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis (C) |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Jaw Joint Pain |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Kidney or Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Thirst | <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Ulcers or G.I. Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Use Tobacco |
| <input type="checkbox"/> HIV-AIDS-ARC | <input type="checkbox"/> X-ray/Chemotherapy |
| <input type="checkbox"/> Heart Attack or Stroke | |

Metrowest Family Dental, 220 N. Main St., Natick, Ma 01760 (508)655-5331
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Are you currently taking or have taken in the past any medications for osteoporosis or osteopenia? Some examples are Fosamax (Alendronate), Actonel (Risendronate), Zometa (Zolendronate) or Boniva (Ibandronate). Yes No If yes, for how long? _____

Do you have any condition or problem not listed about which we should know about? Please explain:

Please list medications you are currently taking _____

Does a physician prescribe prophylactic antibiotic for dental visits? Yes No

Have you ever been given antibiotics before dental treatment? Yes No

Have you recently consumed alcohol? Yes No

Have you recently used drugs? Yes No

Today's Blood Pressure reading _____ **Pulse Rate** _____

Dental History

Do you have any concerns at this time with your dental health? _____

When was your last dental visit? _____

When were your last dental x-rays? _____ When was your last dental cleaning? _____

Have you had a lot of dentistry done over the years? Yes No

Do you have any missing teeth? Yes No Do you wear a removable denture? Yes No

Do you have a history of jaw joint problems? Yes No

Do you clench or grind your teeth during the day or night? Yes No

Have you avoided regular dental care? Yes No If yes, why? _____

Do you feel you have active decay? Yes No

Do you experience frequent bad breath? Yes No

Do you feel you have gum disease? Yes No

Have you ever had gum treatments? Yes No

How often do you brush your teeth? _____ Floss? _____ Use other aids? _____

Are you happy with the appearance of your teeth? Yes No

Would you like your teeth to be whiter? Yes No

Have you ever "bleached" your teeth before Yes No

What are your dental expectations? _____

Name of previous dentist: _____ Address: _____

City: _____ State: _____ Zip: _____

Shall we request your records from your previous dentist? Yes No

How would you rate your previous dental experience? _____

Rate on a scale of 1-10 with 1-poor, 10-excellent



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please 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 acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

Written Financial Policy

Thank you for choosing Metrowest Family Dental for your oral health care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Mastercard, Visa, Discover Card, Cash or Check,

We offer a 5% courtesy adjustment to patients who pay for their treatment in full with cash or check prior to completion of care for treatment plans of \$5000 or more.

- NO INTEREST¹ Payment Plans² from CareCredit

- Allow you to pay over time with NO INTEREST¹
- Convenient, low monthly payment plans² also available
- No annual fees or pre-payment penalties

Please note:

We offer several financing options for all our treatment plans. Please inquire at our front desk.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³

A fee of \$50 is charged for patients who miss or cancel an appointment without at least 24-hour notice.

There is a \$50 returned check fee.

If you have any questions, please do not hesitate to ask. We do our best to give our patients information so that they may obtain their optimum dental care.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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