Avalon Dental Center

PATIENT INFORMATION

(Confidential)

Last Name_____ First Name_____ ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Home Address _____

City_____ State _____ Zip _____

Home Phone Number(____)_____-_____ Work Phone Number(____)_____-_____

Cell Phone Number(____)_____-_____ Email Address_____

Social Security Number_____ Date of Birth_____/_____/_____

Employer_____

If Student: School/College Name_____ City_____ State_____ ☐ F/T ☐ P/T

Emergency Contact _____ Phone Number(____)_____-_____

How Did You Hear About Our Office?_____

Insurance/Account Information

Last Name of Insured_____ First Name _____

Home Address _____

City_____ State_____ Zip_____

Subscriber's Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Relationship to Patient_____ Employer Sponsoring Insurance Plan _____

Insurance Company_____ Group Number_____

Insurance Address _____

City_____State_____Zip_____ Insurance Telephone(____)_____-_____

OFFICE USE ONLY-*Effective Insurance Coverage Confirmation*

Date_____/_____/_____
Phone Number_____
Spoke to_____
Type I_____
Type II_____
Type II I_____
Completed By_____

Deductible: Individual_____Family _____
Annual Maximum_____
Ortho Coverage _____
Missing Tooth Clause_____
Waiting Periods _____
Implants _____

Patient Medical History

Please answer the following questions completely.

Name of Physician _____ **Telephone** (___)____-_____ **Date of Last Exam** ___/___/___

	Yes	No
1. Are you currently under any medical treatment?	☐	☐
2. Are you taking any medications? (Including pain relievers, antibiotics, blood thinners, birth control, antidepressents, etc.?)	☐	☐
If so, what? _____		
3. Women – Are you pregnant or think you may be pregnant?	☐	☐
4. When was the last time a doctor listened to your heart and checked your blood pressure? _____		
Name of doctor _____		

Notes: _____

_____

_____

_____

Do you have/had any of the follows?	Yes	No
Heart Problems?	☐	☐
Heart Murmur?	☐	☐
Mitral Valve Prolapse?	☐	☐
(Does your physician require pre-medication prior to dental treatment?)	☐	☐
Allergy to Asprin?	☐	☐
Allergy to Novocaine?	☐	☐
Allergy to Penicillin?	☐	☐
Any other Allergies?	☐	☐
If so, what? _____		
Diabetes?	☐	☐
Hepatitis? (Type A__B__C__)	☐	☐
Tuberculosis?	☐	☐
High Blood Pressure?	☐	☐
Asthma?	☐	☐
AIDS or HIV?	☐	☐
Sexually Transmitted Disease?	☐	☐
Joint Replacement or Implant?	☐	☐
(Does your physician require pre-medication prior to dental treatment?)	☐	☐
Difficulty Stopping Bleeding?	☐	☐
Glaucoma?	☐	☐

Other Medical Conditions? _____

_____

Patient Dental History

Previous Dentist _____

Dentist Telephone(_____)_____-_____ **Date of Last Exam** _____/_____/_____

Reason for Changing from Previous Dentist _____

What is the purpose of today's visit? _____

Do you have/have you had any of the following?

	Yes	No
1) Teeth sensitive to heat?	☐	☐
2) Teeth sensitive to cold?	☐	☐
3) Teeth sensitive to sweets?	☐	☐
4) Teeth sensitive when biting?	☐	☐
5) Pain in any of your teeth?	☐	☐
6) Swelling in your face or mouth?	☐	☐
7) Problems with previous dental treatment?	☐	☐
8) Bleeding gums?	☐	☐
9) Loose teeth?	☐	☐
10) Do you like your smile?	☐	☐

Comments _____

_____

_____

_____

Health History Update

I verbally reviewed the medical/dental information above with the patient named herein.

Doctor Signature _____

Date____/____/____

Doctors Comments _____

1. Date____/____/____ Changes: Yes/No

Comments _____ Initials_____

2. Date____/____/____ Changes: Yes/No

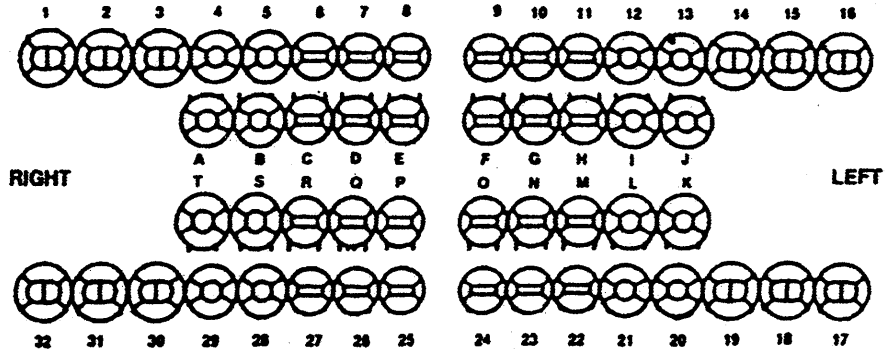
Comments: _____ Initials_____

3. Date____/____/____ Changes: Yes/No

Comments: _____ Initials_____

PATIENT NAME: _____ **EXAM DATE:** _____/_____/_____

Head & Neck	TMJ	Oral Cancer Exam	Consult Recommended	___Yes ___No
Periodontics	Oral Hygiene	Case Type I II III IV	Consult Recommended	___Yes ___No
Orthodontics	Occlusion Type		Consult Recommended	___Yes ___No
Oral Surgery	Extraction #		Consult Recommended	___Yes ___No
Implants	Consult Recommended	____ Yes _____ No		



Arch Rehabilitation
Maxillary Options

Mandibular Options

TOOTH	CLINICAL SIGNS & SYMPTOMS	TOOTH	TREATMENT OPTIONS
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	
7		7	
8		8	
9		9	
10		10	
11		11	
12		12	
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21		21	
22		22	
23		23	
24		24	
25		25	
26		26	
27		27	
28		28	
29		29	
30		30	
31		31	
32		32	

CONSENT FOR TREATMENT

Dr. _____ has explained the nature of my condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches. Just as there may be benefits to the procedure proposed, I understand that all procedures involve risks to some degree. These general risks may occur in connection with the procedure(s) proposed for me: infection, bleeding, numbness, recurrence, or need for further treatment such as root canal therapy, or extraction. I am aware that other unexpected risks or complication may occur and that no guarantees or promises have been made to me concerning the results of any procedure or treatment. It has also been explained that during the course of the proposed procedures, unforeseen conditions may be revealed requiring the performance of additional procedures. I have read this form and have discussed it with my dentist, and I understand it. I request the performance of the procedure(s) described.

_____
Patient Signature Date

I have explained the above statements to the patient and answered all questions.

_____
Doctors Signature Date

TREATMENT ALTERNATIVES

Plans and costs are estimates only. Dental treatment frequently changes in mid-course. Additional Root Canal Therapy may be indicated if symptoms develop after treatment of decayed teeth. Insurance benefits will be coordinated to get you your maximum allowable benefit.

IDEAL TREATMENT

COSMETIC OPTIONS

GOOD DENTISTRY

MINIMAL MAINTENANCE

Please read each section and sign below.

PAYMENT IS DUE IN FULL UPON SERVICES RENDERED

If you have insurance coverage, our staff will calculate estimated insurance payments for services rendered. We cannot, however, be responsible for actual payment made by your insurance carrier. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

AUTHORIZATION AND RELEASE

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or health practitioners.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature of Patient/Parent/Guardian Date

-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)

_____

_____

Avalon Dental Center

120 Temple Street
Somerville, MA 02145

160 Cambridge Street
Cambridge, MA 02141

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is the statement of our Financial Agreement, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service. We accept cash, visa, master card, and Discover.

Should you request, we will be glad to provide you with office payment plan options.

We will be glad to bill to your insurance carrier, however all estimated co-payment amount. Please be advice that any balance left unpaid by your insurance carrier, will be your responsibility.

Here at Avalon Dental Center, we use Composite **(Resin) material only. Please refer to your insurance policy in regards to the contract limitations with posterior multi-surface fillings.** In the event your policy does not provide coverage for these procedures or at a lesser rate of coverage, then again any unpaid balance will be your responsibility. We will be glad to answer any questions you have in regards to this issue.

Being that this is a family oriented practice, we ask that all minors are accompanied by his or her parent or legal guardian. Unaccompanied minors will be denied emergent treatment unless prior consent and financial arrangements have been made.

Appointment Policy

We do require at least 24 hour notice when canceling an appointment. Should an appointment be cancelled or missed with insufficient notice there will be a $50.00 failed appointment be applied to your account and must be settled before additional treatment is rendered. After 3 No-shows we hold the right to dismiss you from our office.

In the days prior to your appointment you may receive a confirmation call which must be returned to confirm that you will indeed be attending your appointment. This is set in place so that we may better serve our patients and their schedules.

I understand there will be a dupplication fee of $15 per chart and this fee must be paid in full along with any balance on my account.

We require positive identification at the time of the appointment.

Please let us know if you have any questions regarding this policy.

By signing below you agree to our office Policies and Procedures.

Signature of Responsible Party:_____Date:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____

Address: _____State:_____Zip:_____

Telephone:_____Email:_____

Social Security: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of our protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Consent: By signing this form, you will consent to our use and disclosure of our protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right of our Notice of Privacy Practice before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read carefully and completely before signing this Consent.

We reserve the right to change our practices as described in our notice of privacy Practices.

If we change our privacy practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of you protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revision of our Notice, at any time by contacting our office Avalon Dental Center at 617-374-9500, or fax: 617-374-9501.

Right to Revoke: You will have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT