WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental heathcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS #/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS #/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS #/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash
_____ Personal Check
_____ Credit Card ____ Visa ____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒
13. Have you had any head, neck, or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plane or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	❒	❒
8. Have you ever taken Fen-Phen/Redux?	❒	❒
9. Have you had any abnormal bleeding?	❒	❒
10. Do you bruise easily?	❒	❒
11. Have you ever required a blood transfusion	❒	❒
12. Have you had a recent weight loss?	❒	❒
13. Do you have a persistant cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
14. Do you use tobacco?	❒	❒
15. Do you use alcohol or cocaine or other drugs?	❒	❒
16. Are you wearing contact lenses?	❒	❒
17. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒
Women Only:		
1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

(OVER)

C Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	❒	❒
2. Penicillin or other antibiotics?	❒	❒
3. Sulfa drugs?	❒	❒
4. Barbiturates, sedatives or sleeping pills?	❒	❒
5. Aspirin?	❒	❒
6. Iodine?	❒	❒
7. Other?_____	❒	❒
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	❒	❒
2. Scarlet fever?	❒	❒
3. Heart defect or heart murmur?	❒	❒
4. Heart trouble, heart attack, or angina?	❒	❒
a. Do you have pain in your chest upon exertion?	❒	❒
b. Are you ever short of breath after mild exercise?	❒	❒
c. Do your ankles swell?	❒	❒
d. Do you get short of breath when you lie down?	❒	❒
e. Do you require extra pillows when you sleep?	❒	❒
5. Pacemaker?	❒	❒
6. Heart surgery?	❒	❒
7. High blood pressure?	❒	❒
8. Low blood pressure?	❒	❒
9. Hepatitis, jaundice or liver disease?	❒	❒
10. Stroke?	❒	❒
11. Sinus trouble?	❒	❒
12. Lung or breathing problems?	❒	❒
13. Asthma or hay fever?	❒	❒
14. Hives or skin rash?	❒	❒
15. Fainting spells or seizures?	❒	❒
16. Diabetes?	❒	❒
17. AIDS or HIV infection?	❒	❒
18. Thyroid problems?	❒	❒
19. Allergies?	❒	❒
20. Arthritis or rheumatism?	❒	❒
21. Joint replacement or implant?	❒	❒
22. Stomach ulcer?	❒	❒
23. Kidney trouble?	❒	❒
24. Tuberculosis?	❒	❒
25. Persistent cough?	❒	❒
26. Cough that produces blood?	❒	❒
27. Cancer?	❒	❒
28. Sexually transmitted disease?	❒	❒
29. Epilepsy?	❒	❒
30. Anemia?	❒	❒
31. Leukemia?	❒	❒
32. Glaucoma?	❒	❒

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

_____

_____

_____

_____

SUMMARY OF MEDICAL HISTORY

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST

ACCENT DENTISTRY
20 MENDON STREET
BELLINGHAM, MA 02019
508-966-1216

Financial Policy and Treatment Consent

Welcome to our office and thank you for choosing us for your dental care. We are committed to providing you with the best possible care; but we need your cooperation and trust.

Payment for all dental services will be due at each appointment where appropriate.

If you have dental insurance, we will process your claims for you following the payment of all estimated costs, co-pays, and deductibles. If you do not have dental insurance, we require payment for all services at the time of treatment.

Payment can be made by Cash, Credit/Debit Card, or Personal Check. However, we reserve the right to decline personal checks at our discretion (**and over $75**) and a social security number must be on file for **ANY** non-cash payments. All Personal Checks returned to our office incur a fee of $25 on the original balance which must be paid immediately in cash.

Patients with an account balance, excluding outstanding insurance claims, must pay their balance in full prior to scheduling or being seated for additional appointments.

Please keep in mind that appointment times are reserved for you. We require a 24 hour courtesy call for appointment cancellations (**72 hours for Monday appointments**). We reserve the right and will charge a fee for appointments broken or cancelled with less than the required notice. We also reserve the right to reschedule patients who are more than 15 minutes late for their scheduled appointments. Please keep in mind that prime appointments such as evenings and Saturdays are reserved on a first come, first served basis, and may be reserved for patients with a consistent attendance history.

I hereby authorize all payments for dental services performed on my behalf or the behalf of my dependants to Dr. Scott Bankhead. I am responsible for all costs associated with the dental treatment I, or my dependents, undertake. I authorize this office to administer such medications and to perform all diagnostic and therapeutic procedures as deemed necessary for proper dental care. I understand that many types of dental treatment and the administration of anesthesia pose certain inherent risks. I have been given an opportunity to discuss those risks with a member of the staff and consent to immediate and future treatment.

I have fully read and understand this policy. I have been given the opportunity to ask questions about anything aforementioned that I do not understand. I agree to all the terms stated above.

Signature of patient/responsible party_____

Privacy Policy/HIPAA Compliance

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care.

We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment:

We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment:

We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations:

We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that

authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.