

Personal Information



DENTAL DESIGNS of NEW ENGLAND
MODERN FAMILY DENTISTRY WITH A GENTLE TOUCH

1. About You

Date _____

Patient Name _____

I prefer to be addressed as _____

Date of Birth _____ Social Security No. _____

(please check) Male Female Child Single Married Widowed
 Divorced Domestic Partnered

Home Address _____

City, Zip _____

Cell No. _____

Home No. _____ Work No. _____ Ext. _____

May we contact you at this work phone? Yes No

Email address(es) _____

We send appt. confirmations through email & text. Please select one or both. Email Text
If you do not have either, indicate which number to reach you. Phone _____

Employer _____

Occupation _____

How did you hear about us? Website Phone Book Chamber of Commerce
 Newspaper Patient/Dentist

Please let us know if someone referred you to us.

Referral's (dentist/patient/staff) Name _____

2. Spouse / Emergency Info

Spouse/Partner _____

Employer _____

Cell No. _____

Work No. _____ Ext. _____

Date of Birth _____

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name _____

Relation _____

Home No. _____

Cell No. _____

Work No. _____ Ext. _____

4. Insurance

Do you have Primary Insurance? Yes No Does it have Dental Coverage? Yes No

Company Name _____

Company Address _____

City, State, Zip _____

Company Phone No. _____ Group No. _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security No. or ID No. _____

Insured's Date of Birth _____ Insured's Employer _____

Insured's Employer Address _____

3. Responsible Party

Self Other

If other than yourself, please list the person responsible for the account and their information below.

Name _____

Social Security No. _____

Billing Address _____

Home No. _____

Work No. _____ Ext. _____

Relationship to patient _____

Employer Name _____

I authorize release of any information relating to claims filed by **Dental Designs of New England**.

Signature _____

I wish to assign benefits to **Dental Designs of New England** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature _____ Date _____

Health Information



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1. Health History

Today's Date _____

Patient Name _____

Patient Date of Birth _____

Personal Physician _____

Clinic Location _____

Phone No. _____

Please list any serious illness that you've been hospitalized for in the last 5 yrs.

Please list any medications you are currently taking (include over the counter medicines)

Medications	Reasons

Are you currently taking birth control pills? Yes No

Have you ever taken osteoporosis treatment drugs? Yes No

Have you ever taken blood thinners? Yes No

2. Allergies

Please circle if you have any allergies to the following:

- | | | | | |
|-------------|-----------------|--------------|------------------|-------------|
| Axomicillin | Aspirin | Erythromycin | Metals / Jewelry | Sulfa |
| Anesthetics | Codeine | Latex | Pennicillin | Tetracyline |
| Novocaine | Other (explain) | | | |

If any items are circled, please describe symptoms:

I hereby certify that the information I have given here today is correct to the best of my knowledge.

Signature _____ Date _____

3. Conditions

Please circle if you have ever had any of the following diseases or medical conditions.

- | | |
|---|---------------------------|
| Alzheimer's / Memory Loss | Hepatitis A B C D |
| Anemia | High / Low Blood Pressure |
| Angina | HIV / AIDS |
| Arthritis | Liver Disease |
| Artificial Heart Valves, Hips or Joints | Kidney Problems |
| Asthma / Hay Fever | Migraines |
| Blood Transfusions | Mital Valve Prolapse |
| Cancer / Chemotherapy | Pacemaker |
| Cold Sores / Herpes | Radiation Treatments |
| Congenital Heart Defect | Rheumatic / Scarlet Fever |
| Diabetes | Shingles |
| Difficulty Breathing | Smoking / Tobacco |
| Drug / Alcohol Abuse | Sinus Problems |
| Emphysema | Stents Placed in Heart |
| Epilepsy / Seizures / Fainting | (Date _____) |
| Gastrointestinal Disorder / Acid Reflux | Stroke |
| Glaucoma (Narrow Angle) | Snoring / Sleep Apnea |
| Headaches (Severe, Frequent) | Thyroid problems |
| Hearing Impaired | Tuberculosis |
| Heart Attack | Tumor Growth |
| Heart Murmur | Ulcers |
| Heart Surgery | Venereal Disease |
| Hemophilia / Abnormal Bleeding | |
| Other / Surgeries | |

Are you pregnant? Yes No

Are you currently nursing? Yes No

Are you taking blood thinners? Yes No

Are you taking supplements? Yes No

Would you like to speak privately with the Doctor about any problems?

Yes No

4. Pre-Medication

Antibiotic pre-medication may be necessary if you have had or currently have the following:

1. Prosthetic cardiac valve
2. Previous bout of infective bacterial endocarditis
3. Cardiac transplant patients who have had valvulitis
4. Congenital heart disease excluding mitral valve prolapse
5. Joint replacements

Dental Information



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1. Meeting Patient's Immediate Needs

Patient Name _____

What brings you here today? Check-up Time Problem Other (explain)

Why are you changing dental offices? Insurance Location Didn't Like
 Other (explain)

Do you have problems with your teeth now? Yes No
If Yes (check) Hot Cold Sweet Food-Caught Broken Tooth
 Other

2. Past Dental History

When was the last time you saw a dentist?
 1st visit 6 mo. 1 yr. 2 yrs. 3+ yrs.

Former Dentist _____

Clinic Location _____

Phone No. _____

Last Visit _____

What treatment did you receive? Preventive Basic Fillings Major Restoration

Was that a comfortable experience? Yes No

Why? _____

Did you have any treatment that was recommended but not yet completed? Yes No
If yes, what was it? _____

3. Home Care & Perio History

What do you do at home to take care of your oral health? Mouthwash Yes No

Brush; How often _____ Floss; How often _____

Any bleeding when you brush or floss your teeth? Yes No

Concerned about (check) Bad Breath Taste

Other (explain) _____

4. Cosmetic

Are you happy with your smile? Yes No

Anything you would like to change if you could? Yes No

Color Shape Position Straighter

Replace Missing Teeth

Detail (if needed) _____

5. Fears or Anxieties

Is there anything you don't like about dental appointments?

Discomfort Fee Time Inconvenience Afraid

Other (explain) _____

6. Lifetime Smile Plan

We will provide you with education about the health of your mouth so that you can make choices for yourself. This allows you to save your teeth for the rest of your life, while being happy about the way they LOOK and FEEL.

We will teach you about what is HEALTHY and UNHEALTHY, and provide you with the alternatives to treating the unhealthy areas. We will inform you of the risks advantages and disadvantages of treating or not treating your teeth as well. One of the alternatives will always be "TO DO NOTHING." We will always inform you of your costs and what you can expect from your insurance before you schedule your treatment, so there will never be any surprise.

7. Do You Have Any Questions for the Doctor?



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Consent to Treatment

1. I authorize the doctor or designated staff to take x-rays and/or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of

_____ 's needs.

2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.

5. I agree to have Dental Designs of New England share my dental and medical information with other specialists as necessary for my treatment and complete oral health.

6. I agree to keep my reserved dental appointments. If I must cancel an appointment, I agree to give 24 hours advanced notice.

Signature

Date
