PATIENT INFORMATION QUESTIONNAIRE

TODAYS DATE:_____

How did you hear about our practice? _____ Social Security # _____

Patient's Name _____Marital Status Select One Birthdate_____

Address _____ City _____ ST____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager_____ E-Mail_____

Employer _____ City _____ Occupation _____

Name of Spouse / Parent / Guardian_____ Birthdate_____
(circle one) Social Security # _____

Address if different_____ City_____ ST_____ ZIP_____

Home Phone _____ Work Phone_____ Ext_____

Employer _____City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____ Phone _____

DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME_____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP_____

INSURANCE PHONE _____

GROUP / POLICY # _____

EMPLOYEE SS # _____

BIRTHDATE _____

SECONDARY DENTAL INSURANCE INFO

EMPLOYEE NAME _____

INS CO NAME_____

INS CO ADDRESS _____

INS CO CITY, ST ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

EMPLOYEE SS # _____

BIRTHDATE _____

ASSIGNMENT and RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records may be used by the dentist if he so determines. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I certify that I have read or had read to me, the contents of this form.

: Signature _____ Date _____
Parent or Guardian if a minor

HEALTH HISTORY

Today's Date_____

Patient's Name Prefer to be called Date of Birth

_____

Physician's Name and Address

_____

Physician's Phone

_____

Date of your most recent visit to Physician Reason

_____ _____

How would you assess your general Health? ◯ Good ◯ Fair ◯ Poor

OFFICIAL USE ONLY

Yes No

Pre-Med

Comments:

BP:

Pulse:

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition?	☐	☐
2. Have you been hospitalized within the last year? If yes, explain:	☐	☐
3. Have you had a serious illness or operation within the last year? If yes, explain:	☐	☐
4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	☐	☐
5. Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	☐	☐

Do you now or have you had any of the following diseases or problems?

	Yes	No
Cardiovascular Disease ……	☐	☐

If yes, check any that apply:

- ☐ heart disease
- ☐ coronary bypass
- ☐ angina
- ☐ mitral valve prolapse
- ☐ high blood pressure
- ☐ hardening of the arteries
- ☐ stroke
- ☐ heart murmur
- ☐ congestive heart failure
- ☐ heart attack

	Yes	No
Rheumatic fever or rheumatic heart disease	☐	☐
Congenital heart defects	☐	☐
Prosthetic (artificial) heart valves	☐	☐
Pacemaker? If yes, date of placement _____	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Are you short of breath after mild exercise?	☐	☐
Do your ankles swell?	☐	☐
Do you get short of breath when you lie down?	☐	☐
Do you have chest pain upon exertion?	☐	☐
Abnormal bleeding or extended clotting time	☐	☐
Frequent or unexpected nose bleeds	☐	☐

Your normal blood pressure

_____/_____

HEALTH HISTORY

	Yes	No
Diabetes?	☐	☐
If yes, do you require insulin?	☐	☐
Type and Dose _____		
Do you have an artificial joint?	☐	☐
If yes, which joint(s)? _____		
Hepatitis?	☐	☐
If yes, check type:		
☐ Type A ☐ Other		
☐ Type B ☐ Non-Specific Type		
☐ Type C ☐ Don't know		
Have you ever required a blood transfusion?	☐	☐
If yes, what was the date of the transfusion? _____		
Are you HIV positive?	☐	☐
Do you have any reason to suspect that you have been exposed to the HIV virus	☐	☐
Have you ever had Tuberculosis (TB)?	☐	☐
Have you ever had a TB test?	☐	☐
Do you have a cough that has lasted more than 3 weeks?	☐	☐
Do you ever cough up blood?	☐	☐

CHECK ANY THAT APPLY:

☐ Allergies	☐ Glaucoma
☐ Alzheimer's Disease	☐ Heart Disease
☐ Anemia	☐ Herpes
☐ Angina	☐ HIV / AIDS
☐ Asthma	☐ Jaundice or Liver Disease
☐ Arthritis	☐ Joint Replacement
☐ Autoimmune Disease	☐ Kidney Disease
☐ Blood Disorder	☐ Organ Transplant
☐ Cancer	☐ Osteoporosis
☐ Chemo Therapy	☐ Parkinson's Disease
☐ Chronic/ Recurring Sinus Problems	☐ Radiation Treatment
	☐ Respiratory Problems
☐ Cirrhosis	☐ Serious/Frequent Headaches
☐ Depression	☐ Sexually Transmitted Disease
☐ Diabetes	☐ Skin Problems
☐ Drug or Alcohol Treatment	☐ Tuberculosis
☐ Eating Disorder	☐ Ulcers
☐ Epilepsy or Other Seizures	☐ Other_____

Do you consider yourself currently under an abnormally high amount of stress?	☐	☐
Have you had any unexplained or unplanned weight loss recently?	☐	☐
Do you now or have you ever smoked?	☐	☐
(Please circle) Cigarettes Pipe Cigar Other		
If you currently smoke, how much?_____		
If you have smoked in the past but no longer smoke, when did you quit? _____		
Do you chew tobacco?	☐	☐
If yes, how often? _____		
Do you drink alcohol?	☐	☐
If yes, how much? _____		

HEALTH HISTORY

If you are <u>currently</u> taking these medications, check the box on the left. If you have taken any of these medications within the <u>past year</u>, but are not taking them currently, check the box on the right.

Now	Past Year	
☐	☐	Antibiotics
☐	☐	Antidepressants (Prozac, Zoloft, etc.)
☐	☐	Antihistamines
☐	☐	Blood Pressure Medicine
☐	☐	Blood Thinners
☐	☐	Cortisone (Prednisone, etc.)
☐	☐	Cholesterol Medication
☐	☐	Decongestants
☐	☐	Diuretics (water pills)
☐	☐	Hormones (birth control pills, estrogen)
☐	☐	Inhalants
☐	☐	Insulin
☐	☐	Medicine for Heart Problems
☐	☐	Muscle Relaxants
☐	☐	Nitroglycerine
☐	☐	Pain Medicine (Aspirin, Advil, Tylenol, etc.)
☐	☐	Prescription Pain Medication
☐	☐	Sleeping Pills
☐	☐	Thyroid Medicine
☐	☐	Tranquilizers
☐	☐	Vitamins
☐	☐	Others _____

Please list all current medications you take below:

Are you <u>ALLERGIC</u> to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

- ☐ Antibiotics (penicillin, tetracycline, etc .)
- ☐ Local Dental Anesthetics (novacaine)
- ☐ Codeine
- ☐ Aspirin
- ☐ Barbituates or Sedatives
- ☐ Tranquilizers
- ☐ Others _____

	Yes	No
Have you ever had an adverse reaction like nausea, dizziness, or feeling “spacey” with any drug or medication?	☐	☐
Do you have any disease, condition or problem not previously listed that you feel we should know about?	☐	☐

WOMEN:

	Yes	No
Are you currently pregnant? Expected delivery date _____	☐	☐
Do you take birth control meds?	☐	☐
Are you nursing?	☐	☐
Are you currently on hormone replacement therapy?	☐	☐
Have you had a mammogram? Date _____	☐	☐

HEALTH HISTORY

Are you in any discomfort now? Select Where?_____ How long?_____

When was your last visit to a dentist?_____ What was done?_____

How often do you visit a dentist?_____ Date of last x-rays?_____

Have you had teeth extracted? Select Any complications?_____

Are your teeth sensitive to Hot Select Cold Select Sweets Select Pressure Select

Have you had braces? Select When?_____ Have you had periodontal (gum) treatments? Select When?_____

Have you ever worn a "night guard" ? Select Do you snore? Select

How often do you brush your teeth?_____ Do you use an electric brush? Select Floss? Select How often?_____

Do you use any other teeth cleaning aids?_____

Do your gums ever bleed? Select When?_____

Does food wedge between certain teeth? Select Where?_____

Does your jaw ever click or pop? Select Where and when?_____

Do you get frequent headaches? Select Do you ever wakeup with a headache? Select How often?_____

Are you aware of any lump or swelling in your mouth? Select Do you bite your fingernails? Select

Were you satisfied with your previous dentist? Select Explain_____

What are your expectations of our office?_____

What are your goals for your mouth, teeth and smile?_____

Are you unhappy with the appearance of your teeth?_____

Would you like your smile to look better or different?_____

Would you like your teeth to be whiter? Select

Please check any of the following which have kept you from having the best dental care possible:

☐ Fear of Pain ☐ Cost of Treatment ☐ Lack of Concern ☐ Missing Work Time

I certify that I have read and understand the questions above. Any questions that I had in regards to these questions have been answered to my complete satisfaction. I will not hold Dental Partners of Newburyport, LLC or any other member of the staff of this office responsible for any errors or omissions that I may have made in completion of this form. I will advise this office and the doctors of any changes in my physical, dental or general health condition as well as changes in my medications.

_____ _____

Signature (parent/guardian) Date

OFFICE POLICY

Dental Partners of Newburyport
Family & Esthetic Dentistry
www.dentalpartnersofnewburyport.com

Office Policy

Thank you for choosing our office for your achieving and maintaining dental health. We are committed to the success of your dental treatment and want to provide you with the best service available. In order to maintain operation of our office in the highest standard of comprehensive care, it is necessary to collect payment for services when treatment is rendered.

Please choose one of the following:

- ○ I will bring a check or cash to each appointment to pay for the services performed that day. I understand I may not be treated if payment can not be collected on the day of treatment.
- ○ I will use a major credit card for the services performed at each visit or for the portion my dental insurance does not cover.
- ○ For treatment amounts over $300, I am interested in the possibility of an extended payment plan.

- **To patients with dental insurance:**

  Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is delivered to you, your co-payment will be expected at that time. If your insurance company fails to pay within 30 days after we submit your claim, you will be responsible for the full fee.

- **To all patients:**

  We request **48 hours** notice for any appointment change. It is our policy to charge a fee for any appointment that breaks these criteria. A broken appointment is one that you either do not show up for or do not cancel prior to 48 hours of your scheduled appointment. If your appointment was scheduled for a Monday you must cancel your appointment by Thursday of the previous week, as we do not have office hours Friday. We do **not** accept cancellations left on our answering machine. *Such policies are standard practice for health care providers who work one-on-one with patients.*

Acceptance Agreement

I understand and agree with the above office policy. I understand that the parent, relative, or anyone else bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party: _____
Printed Name

_____ _____
Signature Date

ACKNOWLEDGEMENT of PRIVACY PRACTICES

Dental Partners of Newburyport, LLC
194 High Street
Newburyport, MA 01950
(978)465-5358
www.dentalhealthforlife.com

Acknowledgement of Privacy Practices

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment within this office and possibly among a number of health care providers directly and/or indirectly
- Obtain payment from third-party payers (insurance) for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to receive and review a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above 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 used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

Dependent Family Members also covered by this acknowledgement:

_____

_____

For Office Use only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* because:

☐ The patient refused to sign ☐ Communication Barriers

☐ Emergency Situation ☐ Other:_____

Dental Partners of Newburyport, LLC
Drs. St. Clair, Beliveau & Strauss
www.dentalpartnersofnewburyport.com

What to expect at your 1st appointment

In keeping with the high standards our staff strives to always maintain, your first appointment will include a comprehensive examination. This examination is professionally designed to enable our staff to perform any and all future dental needs to the highest standard of abilities available today, giving us totally accurate and thoroughly detailed diagnostic records of your individual needs. We treat every new patient the same regardless of whether the patient feels they need a large amount of dental work or none at all. Our reason for this is because we pride ourselves on being thorough. You will be examined by a physician of the masticatory system, not just a "tooth doctor". There are many relationships between oral health and overall health that are often overlooked. We look beyond the teeth to give you a full picture and understanding of your individual situation. You very well may be 100% healthy but you deserve to have a comprehensive exam and to fully understand your status. ***(Please be advised that depending upon your dental needs, you may or may not have your teeth "cleaned" at your first appointment)***

This visit will begin with record taking and recording and then proceed forward with a full examination and consultation with one of the doctors. We evaluate four areas on every patient:

Esthetics:
- Complete set of intraoral photographs
- Esthetic Analysis

Biology:
- Oral cancer exam, as recommended by the American Cancer Society
- Gum depth measurements around each tooth detecting any gum disease. Your gum health will be classified in a system designed by the American Academy of Periodontology. Your subsequent hygiene appointment will be determined by this portion of the exam and be specifically tailored to your individual needs
- Only necessary x-rays showing all of your teeth and the surrounding bone

Function:
- Complete oral, facial and joint muscle palpation, showing function or dysfunction
- Upper and lower mounted impressions (if indicated)
- Function and diagnosis of the TMJ, your jaw joint

Structure:
- Existing present condition of each tooth, i.e. decay, fillings, crowns, cracks, etc.

Your doctor will then gather all of this information, breaking it down into easy to understand detail and review this with you at a subsequent appointment if necessary. We want you to understand what your dental status is in all these areas, today, as well as where we believe you are headed in the future. **You will never be pressured to do treatment.** You will be highly educated in your dental status and will be able to decide on what treatment is right for you.

It is a known fact that the conditions of the mouth and teeth have a direct affect on your overall physical health and quality of life. It is our job to educate you about your dental health, your job to make decisions about the treatment you receive and our commitment to provide the best dentistry has to offer.