



Dr/Mr/Mrs/Ms/Miss First: _____ Last: _____ Nickname: _____
 Name of Guardian (if patient is a minor): _____ Relationship: _____
 Date of Birth: _____ SSN: _____ Sex: Male/Female Marital Status: S/M/D/W
 Street: _____ City: _____ State: _____ Zip: _____
 Employer/School: _____ Occupation: _____
 Home Phone: () - Work Phone: () - Cell Phone () - Preferred contact H/W/C
 Email Address: _____ May we contact you by email? Yes/No
 Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
 Name of person financially responsible for this account: _____ Relationship: _____

How did you hear about Comfort Dental Weymouth?

Television Brochure Live Nearby Yelp Internet Friend/Relative Other: _____

Insurance Information:

Do you have dental insurance? Yes/ No

Do you have secondary dental insurance? Yes/ No

| | |
|-------------------------------------|-------------------------------------|
| Subscriber Name | Subscriber Name |
| Subscriber SSN | Subscriber SSN |
| Subscriber DOB | Subscriber DOB |
| Patient Relationship to Subscriber: | Patient Relationship to Subscriber: |
| Employer Name: | Employer Name: |
| Employer Phone | Employer Phone |
| Insurance Company | Insurance Company |
| Group Number | Group Number |
| Phone Number | Phone Number |

I understand that I am financially responsible for any treatment performed, whether or not I have Dental Insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment that my insurance company does not cover.

Signature: _____ Date: _____

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED

THE INVESTMENT NECESSARY TO COMPLETE DENTAL TREATMENT IS AN ESTIMATE BASED ON INFORMATION FROM OUR EXAMINATION. SHOULD ADDITIONAL PROBLEMS ARISE AS TREATMENT PROGRESSES, THIS ESTIMATE MAY BE REVISED.

MEDICAL HISTORY INFORMATION

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

| | | |
|-----------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Do you have any of the following diseases or problems? | Yes | No |
| Active tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough greater than a 3 week duration | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough that produces blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Been exposed to anyone with tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| If you answer yes to any of the 4 items above, please stop and return this form to the receptionist | | |

Dental Information

| | | | | | |
|-------------------------------------------------------------|-----|----|-----------------------------------------------------------|-----|----|
| | Yes | No | | Yes | No |
| Do your gums bleed when you brush or floss? | | | Do you have earaches or neck pain? | | |
| Are your teeth sensitive to cold, hot, sweets, or pressure? | | | Do you have any jaw discomfort? | | |
| Does food or floss catch between your teeth? | | | Do you grind your teeth? | | |
| Is your mouth dry? | | | Do you have any sores or ulcers in your mouth? | | |
| Have you had any periodontal (gum) treatments? | | | Do you wear dentures or partials? | | |
| Have you ever had orthodontic (braces) treatment? | | | Do you participate in active recreational activities? | | |
| Is your home water supply fluoridated? | | | Have you ever had a serious injury to your head or mouth? | | |
| Do you drink bottled or filtered water on a regular basis? | | | Date of your last dental visit: | | |
| | | | What was done at that time? | | |
| Are you currently experiencing dental pain or discomfort? | | | Date of last dental x-rays | | |

| |
|-----------------------------------------------------------------------------|
| What is the reason for your dental visit today? |
| How do you feel about your smile? |
| What is your dental anxiety level? (please circle) (least) 1 2 3 4 5 (most) |
| Have you had any problems associated with previous dental treatment? |

Medical Information

| | | | | | |
|--------------------------------------------------------------|--------------------|----|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----|
| | Yes | No | | Yes | No |
| Are you now under the care of a physician? | | | Have you had a serious illness, operation, or been hospitalized in the past 5 years? | | |
| Physician's Name: _____ Address: _____ | Phone: () - _____ | | | If yes, what was the illness or problem? | |
| Are you in good health? | | | Are you taking or have you recently taken any prescription or over the counter medicine(s)? | | |
| Has there been a change in your health within the past year? | | | | If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | |
| If yes, what condition is being treated? | | | | | |

Dental Information

| | | | | | |
|----------------------------------------------------------------------------------------------------------------|-----|----|---------------------------------------------------------------------------------------------------------------|-----|----|
| | Yes | No | | Yes | No |
| Do you wear contact lenses? | | | Joint replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ | | |
| Do you use tobacco? | | | | | |
| Allergies- Are you allergic to or have you had a reaction to: (To all yes responses, specify type of reaction) | | | | | |
| Local anesthetics _____ | | | Metals: _____ | | |
| Aspirin: _____ | | | Latex (rubber): _____ | | |
| Penicillin or other antibiotics: _____ | | | Iodine: _____ | | |
| Barbiturates, sedatives, or sleeping pills: _____ | | | Hay fever/seasonal: _____ | | |
| Sulfa drugs: _____ | | | Animals: _____ | | |
| Codeine or other narcotics: _____ | | | Food: _____ | | |
| | | | Other: _____ | | |

Please indicate if you have or have had any of the following

| | Y | N | | Y | N | | Y | N |
|----------------------------------------------------------------------------------------------------------------------------|---|---|--------------------------------|---|---|------------------------------------|---|---|
| Artificial (prosthetic) heart valve | | | Autoimmune Disease | | | Fainting spells/seizures | | |
| Previous infective endocarditis | | | Rheumatoid Arthritis | | | Sleep Disorder(Sleep Apnea) | | |
| Damaged valves in transplanted heart | | | Systemic Lupus Erythematosus | | | Kidney Problems | | |
| Congenital Heart Disease | | | Asthma | | | Special Needs | | |
| Unrepaired, cyanotic CHD | | | Bronchitis | | | Osteoporosis | | |
| Repaired (completely) in last 6 months | | | Emphysema | | | Persistent swollen glands in neck | | |
| Repaired CHD with residual effects | | | Hepatitis: Circle A / B / C | | | Diabetes (Circle Type 1 or Type 2) | | |
| Cardiovascular Disease | | | AIDS/HIV | | | Glaucoma | | |
| Angina | | | Congestive Heart Failure | | | Stroke | | |
| Arteriosclerosis | | | Heart Murmur | | | Damaged Heart Valves | | |
| Heart Attack | | | Other Congenital Heart Defects | | | Low Blood Pressure | | |
| High Blood Pressure | | | Mental Health Disorders | | | Mitral Valve Prolapse | | |
| Recurrent Infection | | | Tuberculosis | | | Neurological Disorders | | |
| Sinus Troubles | | | Chronic Pain | | | Cancer/chemotherapy/radiation | | |
| Liver Disease / Jaundice | | | Malnutrition | | | Gastrointestinal Disease | | |
| Eating Disorder | | | Ulcers | | | Thyroid Problems | | |
| GE Reflux/Heartburn | | | Sexually Transmitted Disease | | | Severe headache/migraines | | |
| Severe/rapid weight loss | | | Excessive Urination | | | Women: Are you pregnant? | | |
| Has a physician or previous dentist recommended that you take prophylactic antibiotics prior to dental treatment? | | | | | | | | |
| If you answered YES to any of the above questions, or you have a condition that is not listed above, please explain | | | | | | | | |

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his or her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form

Signature of Patient/Guardian: _____ Date: _____



To Our Patients:

Welcome to our office! We are delighted that you have selected us for your dental health care services. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Policy: Payment is due at the time of service. We accept Mastercard, Visa, Discover, American Express, Care Credit, Lending Club, Checks, Debit Card, and Cash.

All overdue accounts will be assessed an annual 18% finance charge and you will be responsible for any collection service fees. There will be a \$35.00 fee assessed for any checks returned unpaid.

Insurance Policy: Co-payments are due at the time of service. (ie: Your estimated share of costs that your insurance company will not cover. This amount will be due at the time of service).

We are pleased to assist you in processing your dental insurance. However, dental insurance policies are a contract between the patient and the insurance company. Therefore, we request that you keep your account current with us and personally consult your insurance company for services not covered.

Coupon Offerings: Payments and coupons must be presented at time of check-in.

Cancellation Policy: Please be aware that confirmation calls are a courtesy service only. Patients are responsible for their appointments. If you miss an appointment and fail to notify us at least 24 hours in advance, a missed appointment fee of between \$30.00 and \$100.00 will be billed to your account.

Thank you again for selecting us as your Dental HealthCare Provider.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

Subject to credit approval. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.