



Patient Registration

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State / Zip: _____

Responsible Party (for patients under 18): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security Number: _____

I would prefer *NOT* to receive correspondences via text message I would prefer *NOT* to receive correspondences via email

Email: _____

How did you hear about our office? _____

Primary Insurance Information

Secondary Insurance Information

Subscriber Name: _____

Subscriber Name: _____

Subscriber DOB: _____

Subscriber DOB: _____

Subscriber Address (if different):

Subscriber Address (if different):

Employer: _____

Employer: _____

Insurance Company: _____

Insurance Company: _____

Insurance Phone: _____

Insurance Phone: _____

Member ID#: _____

Member ID#: _____

Plan Group#: _____

Plan Group#: _____

Patient Name:

Birth Date:

Date Created:

Disclaimer

Although dental professionals focus on the head and neck, your oral health is directly connected to your overall health. Please answer the following questions honestly. If you do not feel comfortable answering any of the information, please leave it blank and your clinician will review it with you.

Gender:

Weight:

Are you under a physician's care now? (If yes, please write contact info) Yes No If yes:

In the past 2 years, have you been hospitalized? (If yes, please describe) Yes No If yes:

Have you ever had a serious head or neck injury? Yes No If yes:

Do you currently use tobacco in any form? (If yes, please list) Yes No If yes:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Any past history of joint replacement? Yes No

Any past or current history of eating disorders? Yes No

Have you ever felt someone is trying to control your life - physically, sexually, emotionally or financially? Yes No

Do you use any controlled substances? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Anything else not listed you are allergic to? Yes No If yes:

Please list any prescribed medications, over the counter medications or vitamins you are currently taking:

Current Health

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed Yes No If yes:

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:

X

Date: _____



Seaport
DENTAL ASSOCIATES

Call: 617-73-SMILE

Dental History

Reason for visit _____ Former Dentist/Location _____

Date of last dental visit _____ Date of last dental x-rays _____

Check to indicate if you have any of the following:

- | | | | |
|--------------------------|-----------------------|-----------------------|-----------------------|
| Bad Breath | <input type="radio"/> | Lip or Cheek Biting | <input type="radio"/> |
| Bleeding Gums | <input type="radio"/> | Loose Teeth | <input type="radio"/> |
| Broken Fillings | <input type="radio"/> | Mouth Breathing | <input type="radio"/> |
| Clicking/Popping Jaw | <input type="radio"/> | Mouth Pain | <input type="radio"/> |
| Dry Mouth | <input type="radio"/> | Orthodontic Treatment | <input type="radio"/> |
| Fingernail Biting | <input type="radio"/> | Pain Around Ear | <input type="radio"/> |
| Food Collection in Teeth | <input type="radio"/> | Periodontal Treatment | <input type="radio"/> |
| Foreign Objects | <input type="radio"/> | Sores in Mouth | <input type="radio"/> |
| Grinding teeth | <input type="radio"/> | Sensitivity to Cold | <input type="radio"/> |
| Gums Swollen/Tender | <input type="radio"/> | Sensitivity to Heat | <input type="radio"/> |
| Jaw Pain or Tiredness | <input type="radio"/> | Other _____ | |

How often do you brush your teeth? _____

How often do you floss your teeth? _____

If you can change **anything** about your smile, what would you change?

Smile Survey

Please take a moment to fill out this smile survey so that we will be able to better accommodate your dental Needs. Below is a list of services we are proud to provide. If you are interested in learning more about these services, please speak to your hygienist or dentist during your visit!



-I am happy with my smile	YES	NO
---------------------------	-----	----

I would like to talk to the hygienist/dentist about:

-Bleaching / Teeth Whitening	YES	NO
------------------------------	-----	----

-Straightening my teeth with Invisalign©	YES	NO
--	-----	----

-Composite “White” Fillings	YES	NO
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-I would like information on improving my smile	YES	NO
---	-----	----

-I would like more information on Botox/Dermal Fillers	YES	NO
--	-----	----

-I would like more information on treatment options for	YES	NO
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TMJ and headaches

-I would like more information on:



Call: 617-73-SMILE

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this we have **an Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled that time has been set aside for you, and when it is missed that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **\$50.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if you are more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **\$50.00** cancellation fee will be applied.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice

Patient Signature

Date



Call: 617-73-SMILE

Financial Policy

Our office is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility. Patients must complete all information forms prior to seeing the dentist. A copy of your insurance card(s) will be retained for your file. If your insurance changes, it is your responsibility to notify our dental office of that change.

Payments

Co-Payments: By law, we must collect your carrier-designated co-payment at the time of service. Please be prepared to pay that co-payment at each visit.

Non Co-Payment Plans: If your plan does not require a co-payment and we participate in your plan, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

Self-Pay: Payment is expected at the time of service.

Account Balances: You are responsible for timely payment of your account. Our offices reserve the right to reschedule or deny a future appointment on any delinquent accounts.

Return Check Policy and Fee

We accept local and out of state checks. Any check that is not cleared through the bank and is returned to our office because of an insufficient balance will be returned to the patient and the patient will be charged \$15.00.

Providing Insurance Information

Insurance coverage is a contract between you and your carrier.

It is your responsibility to provide Seaport Dental with valid insurance information prior to your appointment. In the event that you can not provide the information, or the coverage is not active, Seaport Dental will ask you to pay in full for all services at the time of your visit.

If valid information is provided within 30 days of your visit, Seaport Dental will bill the new insurance and once payment is received your account will be refunded. Refunds can be used towards future work or made to the **original** form of payment. Seaport Dental does not keep any credit card numbers so you will need to contact the office to provide that information.

If updated insurance information is received **after** 30 days from the date of your visit Seaport Dental will provide you with the information to submit the claim for reimbursement. Your insurance company will pay you directly. No refunds will be made by Seaport Dental and we will be unable to honor any insurance negotiated fees on contract adjustments.

Dental Insurance

As a courtesy to our patients, we will file your dental claims and accept assignment of benefits from participating insurance providers. In order for us to be able to provide this service, please provide us with accurate dental information. There are many different types of insurance policies available. Your employer has arranged this contract between you, your employer and the insurance company. We are not a party to this contract. **Ultimately, any balance remaining for services is your responsibility.** Our staff will assist you in obtaining your maximum benefits under the guidelines of your policy.

“Usual and Customary” is a term developed by the insurance carrier industry to reflect “average charges” from specific dentists in designated geographic localities. The usual and customary amount noted on the explanation on benefits does not accurately reflect individual charges. Therefore, the usual and customary charges DO NOT override our fees. **THANK YOU** for taking the time to review our policy. Please feel free to ask any questions or share specific concerns.

Patient Signature _____ Date _____

If patient is a minor, please state your relationship _____

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMEX, DISCOVER, CARE CREDIT



Seaport
DENTAL ASSOCIATES

Call: 617-73-SMILE

General Informed Consent

1. I hereby consent to and authorize the performance of dental procedures integral to my general dental care upon “myself” _____ for the following purpose(s):
Preventive procedures including but not limited to; prophylaxis cleanings, examinations, restorations, periodontal treatments, endodontic treatments and diagnostic radiographs.
Seaport Dental complies with the ADA recommendation for radiographs. This includes a minimum of yearly bitewings and a full mouth series once every 5 years.
2. I am aware that during the course of treatment changes in my treatment plan may become necessary. I further understand and necessary changes will be explained to me, and the opportunity will be given to ask questions.
3. I understand that the x-rays, charts and any other results from this treatment will be used for educational purposes when working with dental students.
4. The nature and purposes of the treatments listed above, and any possible risk involved, will be explained fully to me in advance of treatment.
5. This consent will be in effect for the duration of my tenure as a patient of Seaport Dental.
6. I understand that Seaport Dental will assist me in obtaining maximum benefits under the Guidelines of my policy and agree that all costs or balances not covered by my insurance will be my full responsibility.

Patient Signature

Date

Seaport Dental Associates
ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **HIPPA Notice of Privacy Practices**.

(Patient Name)

(Patient Signature)

(Date)

OR

(Signature of Personal Representative)

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other _____

Please Note: It is your right to refuse to sign this Acknowledgement.

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgment.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other: _____

Staff Member signature

Date