Seaport DENTAL ASSOCIATES

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#: _____

Time 11:58 AM

Seaport Dental Associates

Medical History (Updated)

Date 3/16/2016

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	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes 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	○	Lip or Cheek Biting	○
Bleeding Gums	○	Loose Teeth	○
Broken Fillings	○	Mouth Breathing	○
Clicking/Popping Jaw	○	Mouth Pain	○
Dry Mouth	○	Orthodontic Treatment	○
Fingernail Biting	○	Pain Around Ear	○
Food Collection in Teeth	○	Periodontal Treatment	○
Foreign Objects	○	Sores in Mouth	○
Grinding teeth	○	Sensitivity to Cold	○
Gums Swollen/Tender	○	Sensitivity to Heat	○
Jaw Pain or Tiredness	○	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?

_____

Seaport DENTAL ASSOCIATES

Call: 617-73-SMILE

Child Smile Survey!

Have you ever been to a dentist before? YES ☐ NO ☐ Unknown ☐

Have you or your parent/guardian ever had a bad dental experience? YES ☐ NO ☐ Unknown ☐

Do you have any mouth pain? YES ☐ NO ☐ Unknown ☐

Do you take a bottle or a pacifier to bed? YES ☐ NO ☐ Unknown ☐

Does you use toothpaste with fluoride in it? YES ☐ NO ☐ Unknown ☐

Does your family drink water with fluoride in it? YES ☐ NO ☐ Unknown ☐

How often do you brush your teeth? _____

How many sugary drinks does the child drink per week? _____

Examples of sugary drinks: Energy or Sports drinks, Juices, Sodas, Lemonade, Sweetened tea or coffee

Seaport DENTAL ASSOCIATES

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 practive 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

Seaport DENTAL ASSOCIATES 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**. Out 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