New England Smile
Pediatric Dentistry & Orthodontics
233 Water Street, Plymouth, MA 02360 | Tel (508) 591-5951 Fax (508) 659-4637 | www.newenglandsmile.com

Patient Information
(Confidential)

PATIENT

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: (_____) _____ Date of Birth: _____/_____/_____

Child's School: _____

PARENT □ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

Last Name: _____ First Name: _____

SSN#: _____ - _____ - _____ Date of Birth: _____ /_____ /_____

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

Email Address (we offer email appointment confirmations): _____

Emergency Contact: _____ Phone Number: (_____) _____

How did you hear about us? □ Patient: _____

□ Other: _____

Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Primary Insurance Company: _____

Employer: _____

Subscriber SSN#: _____ - _____ - _____ Subscriber ID #: _____

Group Number: _____ Subscriber Date of Birth: _____ /_____ /_____

Secondary Insurance Company: _____

Employer: _____

Subscriber SSN#: _____ - _____ - _____ Subscriber ID #: _____

Group Number: _____ Subscriber Date of Birth: _____ /_____ /_____

If MassHealth:

Patient Name: _____ MassHealth ID #: _____

Medical History

PATIENT NAME_____ Date of Birth: _____ /_____ /_____

Is the patient currently under physician's care: □ YES □ NO Date of Last Visit:_____ /_____ /_____

Physician's Name: _____ Phone Number: (_____) _____

Are all immunizations current: □ YES □ NO

Have you ever been hospitalized: □ YES □ NO If yes, reason: _____

Are you currently taking medications, if yes please list:

_____

Have you ever taken/had □ Fosamax □ Boniva □ Actonel □ Bisphosphonates □ Chemotherapy

Women: Are you □ Pregnant □ Trying to get pregnant □ Nursing □ Taking oral contraceptives

Any Allergies:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Latex □ Nickel □ Sulfa Drugs

□ Local Anesthetics □ Others not listed: _____

Please check any conditions you may have below:

□ AIDS/HIV	□ Cancer	□ Liver/Kidney Disease	□ Prolonged bleeding
□ Anemia	□ Heart Issues/Murmur	□ Steroid Therapy	□ Epilepsy
□ Tuberculosis	□ Diabetes	□ Emotional/Psych Disorder	□ Cerebral Palsy
□ Asthma	□ Learning Disabilities	□ Speech problems	□ Seizures
□ Rheumatic Fever	□ Fainting	□ High Blood Pressure	□ Radiation Treatment
□ Breathing Problems	□ Hepatitis	□ Hearing Loss	□ Thyroid Disease

□ OTHER: _____

Dental History

Has the patient been to the Dentist before: □ YES □ NO Where: _____

Date of Last Visit: _____ /_____ /_____ Is your water fluoridated: □ YES □ NO

Do you use Fluoride toothpaste: □ YES □ NO Mouth Rinse: □ YES □ NO

Does patient have or ever had braces: □ YES □ NO Do you want information about braces: □ YES □ NO

Do you have any of the following:

□ Sensitivity to hot or cold □ Sensitivity to sweet □ Sensitivity to biting □ Bleeding Gums □ Swollen face or mouth

□ Pain in any of your teeth □ Loose Teeth □ Problems with previous dental care: _____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT.
IF I EVER HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM MY DOCTOR AT THE NEXT APPOINTMENT

_____

Patient/Parent/Guardian Signature **Date**

_____

Doctor Signature **Date**

APPOINTMENT CANCELLATIONS

As a courtesy, we make every effort to confirm your appointment one day in advance. However, it should be noted it is your responsibility to keep all appointments. We request a MINIMUM OF 24 HOURS to change or cancel an appointment. A fee may be incurred for all failed or late cancellations. For more than two failed or cancelled appointments you may be placed on same day only appointment basis.

DENTAL INSURANCE

If you have insurance coverage, our staff as a courtesy does their best to determine a proper **ESTIMATE** for you. Due to the many insurance companies and plans we cannot always predict the actual payments your insurance carrier will make. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments, have a credit issued to your account for future services or may be eligible for a refund. By signing this form, I hereby authorize and direct payment of dental benefits from my insurance company to New England Smile, LLC.

If you have Masshealth coverage, please be aware if you have a lapse in your coverage, or a procedure is denied, you are responsible for any out of pocket expenses that incur. You are responsible for understanding the benefits provided to you.

AUTHORIZATION AND RELEASE

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or health practitioners.

INFORMATION REGARDING FILLINGS

Please be advised we no longer use silver (amalgam) fillings on primary (baby) teeth due to substantial improvement in composite/resin (white) filling materials. These new materials have been found to perform better than amalgam on primary teeth. We may still recommend, on occasion, silver (amalgam) fillings in certain cases for permanent (adult) molars or as a request of the parent.

Please be aware that some insurance plans pay differently on composite restorations and your co-payment may be higher. The balance is the patient's responsibility.

Please contact your insurance if you have any concerns. If finances are a concern, we can submit a pre-treatment estimate with your insurance company for the treatment recommended. We will be happy to assist you with that request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read/received a copy of this office's Notice of Privacy Practices.

_____

Patient/Parent/Guardian Signature **Date**

_____

Patient Name

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SOCIAL MEDIA CONSENT

We like to show off all the fun and great things that happen at New England Smile. Often times we do this on social media in the form of photographs or videos and include our patients and their families. Please let us know if we have your permission to post any photographs or videos that may include you or your child on varioud New England Smile social media sites. These may include (but are not limited to) Facebook, Google+, Twitter, and Instagram.

_____

Patient/Parent/Guardian Signature **Date**

_____

Patient Name

Please initial below

I consent to New England Smile social media usage [_____] I do not consent to social media usage [_____]

ELECTRONIC COMMUNICATIONS ENCRYPTION WAIVER

When communicating via electronic media (e.g. email) HIPAA standards require us to utilize encryption technology for your privacy. To keep electronic communications private, we utilize third party encryption methods that typically require a password for viewing. If you prefer to avoid encrypting any emails that may contain private information and opt out of data encryption, please fill out the form below. By opting out of electronic encryption electronic communications will be sent without password protection.

_____

Patient/Parent/Guardian Signature **Date**

_____

Patient Name

Please initial below

I wish to opt out of electronic encryption [_____]