

# Park Street Dental Associates

PLEASE PRINT

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_ TITLE: MR MS MRS DR \_\_\_\_\_  
first middle last

SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOC. SEC. #: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
street city/town state zip

HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ BUSINESS/SCHOOL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ EMPLOYER / SCHOOL NAME: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER / SCHOOL ADDRESS: \_\_\_\_\_  
street city/town state zip

DENTAL INSURANCE CO. NAME: \_\_\_\_\_ INSURED'S NAME: \_\_\_\_\_

INSURED'S SOC. SEC. #: \_\_\_\_\_ INSURED'S EMPLOYER: \_\_\_\_\_ RELATION: \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

FORMER DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_ LAST VISIT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
street city/town state zip

PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_ LAST VISIT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
street city/town state zip

PERSON TO CONTACT IN CASE OF AN EMERGENCY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

1. WHAT REASON BRINGS YOU TO OUR OFFICE? \_\_\_\_\_

2. ARE YOU UNDER THE CARE OF A PERIODONTIST? (YES NO) DR. \_\_\_\_\_ PHONE: \_\_\_\_\_

3. WHEN WAS THE LAST TIME YOU HAD A FULL SERIES (ABOUT 22 FILMS) OF DENTAL X-RAYS TAKEN? \_\_\_\_\_

4. ARE YOU CURRENTLY BEING TREATED BY A DOCTOR? (YES NO) FOR WHAT REASON(S)? \_\_\_\_\_

5. ARE YOU TAKING ANY MEDICATIONS? (YES NO) PLEASE SPECIFY: \_\_\_\_\_

6. ARE YOU ALLERGIC OR SENSITIVE TO ANY MEDICATIONS OR SUBSTANCE (e.g. PENICILLIN, LATEX, ACRYLIC)? (YES NO DK "don't know")

PLEASE LIST: \_\_\_\_\_

7. HAS YOUR PHYSICIAN RECOMMENDED ANTIBIOTICS BEFORE DENTAL TREATMENT? (YES NO DK): \_\_\_\_\_

8. HAVE YOU TAKEN CORTISONE OR HORMONES IN THE PAST 12 MONTHS? (YES NO DK): \_\_\_\_\_

9. DO YOU BLEED EASILY? (YES NO DK): \_\_\_\_\_

10. HAVE YOU EVER HAD HEART PROBLEMS (e.g. MURMUR, PACEMAKER, MITRAL VALVE PROLAPSE, ANGINA)? (YES NO DK): \_\_\_\_\_

11. PLEASE LIST ALL MAJOR SURGERIES OR ILLNESSES: \_\_\_\_\_

12. PLEASE CIRCLE THE ITEMS YOU USE FOR DAILY ORAL HYGIENE:

TOOTH BRUSH (MANUAL OR ELECTRIC) DENTAL FLOSS TOOTH PICKS STIMULATORS (RUBBER TIP) WATER DEVICE

13. WHAT IS YOUR REACTION TO HAVING DENTAL TREATMENT? (please circle) I DREAD IT I WORRY ABOUT IT I DON'T MIND IT

14. WHEN CHOOSING RESTORATIVE DENTISTRY, I WISH TO HAVE? (please circle) HIGHEST QUALITY MOST ECONOMICAL MOST ESTHETIC

15. FOR WOMEN ONLY: ARE YOU PREGNANT? (YES NO DK) IF YES, IN WHAT MONTH OF PREGNANCY ARE YOU IN? \_\_\_\_\_

# Park Street Dental Associates

DO YOU HAVE OR HAVE EVER HAD: (please circle: YES NO DK = DON'T KNOW)

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|--|---|
| <p>16. KIDNEY DISEASE..... YES NO DK</p> <p>17. HEPATITIS / LIVER DISEASE..... YES NO DK</p> <p>18. HIGH / LOW BLOOD PRESSURE..... YES NO DK</p> <p>19. SHORTNESS OF BREATH..... YES NO DK</p> <p>20. SWELLING OF THE ANKLES..... YES NO DK</p> <p>21. ANEMIA..... YES NO DK</p> <p>22. RHEUMATIC FEVER..... YES NO DK</p> <p>23. FREQUENT NOSE BLEEDS..... YES NO DK</p> <p>24. HIV / AIDS..... YES NO DK</p> <p>25. EPILEPSY, FAINTING OR SEIZURES..... YES NO DK</p> <p>26. STOMACH PROBLEMS OR ULCERS..... YES NO DK</p> <p>27. PSYCHIATRIC TREATMENT..... YES NO DK</p> | <p>28. TUBERCULOSIS..... YES NO DK</p> <p>29. ASTHMA..... YES NO DK</p> <p>30. DIABETES..... YES NO DK</p> <p>31. ANOREXIA OR BULIMIA..... YES NO DK</p> <p>32. THYROID DISEASE..... YES NO DK</p> <p>33. VENERAL DISEASES..... YES NO DK</p> <p>34. SKIN DISEASES (inc. HIVES, SKIN RASHES).... YES NO DK</p> <p>35. PAINFUL OR SWOLLEN JOINTS..... YES NO DK</p> <p>36. CANCER..... YES NO DK</p> <p>37. RADIATION OR CHEMOTHERAPY..... YES NO DK</p> <p>38. UNEXPLAINED BRUISES..... YES NO DK</p> <p>39. BAD REACTION TO LOCAL ANESTHESIA.... YES NO DK</p> |
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|--|---|
| <p>40. DIFFICULTY OR PAIN WHEN OPENING YOUR MOUTH WIDE.....</p> <p>41. DIFFICULTY OR PAIN WHEN CHEWING YOUR FOOD.....</p> <p>42. EAR PAIN OR PAIN IN FRONT OF THE EARS.....</p> <p>43. PAIN IN THE FACE, JAWS, EYES, THROAT, OR NECK.....</p> <p>44. HEADACHES (HOW FREQUENT).....</p> <p>45. JAW NOISES THAT BOTHER YOU OR OTHERS.....</p> <p>46. TEETH SENSITIVE TO CHEWING, TEMPERATURE, SWEETS, ETC.....</p> <p>47. A FEELING THAT YOUR TEETH ARE SHIFTING OR LOOSENING.....</p> <p>48. A BAD TASTE IN YOUR MOUTH.....</p> <p>49. BLEEDING GUMS.....</p> <p>50. A GUM ABSCESS OR INFECTION.....</p> <p>51. ROOT CANAL TREATMENT (ENDODONTICS).....</p> <p>52. GUM SURGERY OR TREATMENT (PERIODONTICS).....</p> <p>53. BRACES (ORTHODONTICS) HOW LONG? WHEN COMPLETED?.....</p> <p>54. DO YOU USE TOBACCO?.....</p> <p>55. DO YOU USE ALCOHOL?.....</p> | <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> <p>YES NO DK _____</p> |
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### AUTHORIZATION

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES I MAY NEED.

### FINANCIAL POLICIES

**DENTAL INSURANCE IS VERY DIFFERENT FROM MEDICAL INSURANCE.** WE ARE HAPPY TO EXPLAIN YOUR COVERAGE TO YOU AT ANY TIME. BELOW PLEASE FIND OUR FINANCIAL POLICIES:

1. ALL CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. ANY FIGURES GIVEN TO YOU ARE STRICTLY ESTIMATES, AND ARE OBTAINED AS A COURTESY FOR YOU. ONCE THE INSURANCE COMPANY'S PORTION IS PAID AND IF IT IS DIFFERENT FROM WHAT WAS PREVIOUSLY ESTIMATED, WE WILL EITHER BILL YOU THE DIFFERENCE OR CREDIT YOUR ACCOUNT WITH THE OVERPAYMENT. WE TRY VERY HARD TO CALCULATE THE EXACT COPAYMENT BUT CERTAIN ELEMENTS OF YOUR INSURANCE COVERAGE ME BE UNKNOWN. ANY MONEY STILL DUE AFTER INSURANCE PAYMENTS IS YOUR RESPONSIBILITY AND YOU WILL BE BILLED FOR IT.
2. ANY MONEY PAST DUE BY OVER 30 DAYS WILL BE SUBJECT TO AN 18% PER ANNUM (1½ PER MONTH) FINANCE CHARGE. IN THE UNLIKELY EVENT THAT YOUR ACCOUNT NEEDS TO BE TURNED OVER TO A THIRD PARTY FOR COLLECTION, YOU WILL BE RESPONSIBLE FOR ANY ASSOCIATED COSTS, INCLUDING BUT NOT LIMITED TO ATTORNEY'S FEES.
3. ALL APPOINTMENTS MADE ARE RESERVED EXCLUSIVELY FOR YOUR CARE. A LAST MINUTE CANCELLATION OR A MISSED APPOINTMENT IS EXTREMELY DIFFICULT TO FILL. WE REQUIRE 24 HOUR NOTICE FOR A CANCELLATION, OTHERWISE A FEE OF \$50 FOR EACH HOUR OF A BROKEN APPOINTMENT WILL BE IMPOSED.

**I UNDERSTAND AND AGREE TO ALL THE ABOVE TERMS AND CONDITIONS.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_