Arcadia Dental
620 Old West Central Street
Franklin MA 02038
(508)541-7400

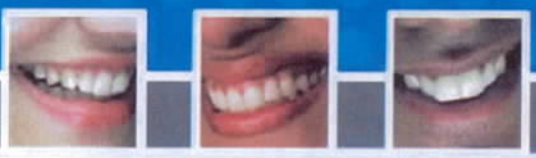

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

HEALTH INFORMATION

Date of Last Dental Visit_____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies:
  ☐ Codeine Allergy
  ☐ Penicillin Allergy
_____
_____
_____

☐ Respiratory Problems
  ☐ Asthma
  ☐ COPD
☐ Tuberculosis
☐ Blood Disease
  ☐ Anemia
  ☐ Excessive Bleeding

☐ Cancer
_____
_____

☐ Radiation Treatment
☐ Diabetes

☐ Fainting
☐ Glaucoma

☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Rheumatic Fever
☐ Pacemaker
☐ High Blood Pressure

☐ Kidney Disease
  ☐ Dialysis
☐ Liver Disease
☐ Hepatitis
☐ Jaundice
☐ Mental Disorders
_____
_____

☐ Nervous Disorders
☐ Epilepsy
☐ Dizziness
☐ Stroke
☐ Pregnancy
  Due date:_____
  Nursing:_____

☐ Artificial Joints
  Date:_____
☐ Arthritis
☐ Rheumatism

☐ Sinus Problems
☐ Stomach Problems
  ☐ Ulcers
  ☐ GERD
☐ Venereal Disease

OTHER:
☐ _____

☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

- Name of Physician:_____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain _____

- Please list all medications that you're taking, prescriptions and supplements

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health. I will inform the doctors at the next appointment without fail.

_____ Date_____

Signature of patient, parent or guardiuan

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

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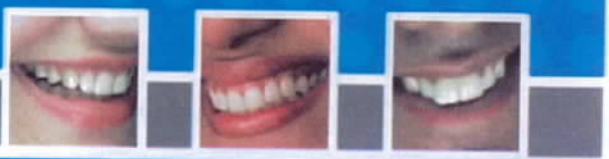

☐ I have read the Notice of Privacy Practices at Arcadia Dental, and grant the staff permission to share my medical information with agents and agencies involved in my care.

Signature of patient, parent, or guardian:

Signature: _____ Date:

Relationship to Patient:

Response Date:

PERIODONTAL HEALTH POLICY

Welcome to Arcadia Dental. At our office every adult patient receives a thorough periodontal evaluation as part of their comprehensive exam. This is required by MA Dental Board, all dental insurance carriers, and our doctors to provide you with a treatment plan.

This is not a painful examination, it takes a few minutes and is done by our hygienists. There is no additional charge for this procedure.

When there are no signs of periodontitis (gum disease) present, we can provide you with a superficial cleaning that would include removal of plaque and tartar above the gumline as well as stains on your teeth. This is called dental prophylaxis.

If there are signs of periodontitis (gum disease) and there is tartar present underneath the gumline, we are required to perform a deeper cleaning. This is called scaling and root planing. This procedure is also not painful, but does require a significant amount of our and your time. Sometimes, the entire mouth is cleaned in a few visits. To maintain the health of your gums, we also recommend that you return for maintenance every 3 months. Seeing our hygienists more frequently will prevent you from building up heavy deposits of tartar and requiring the deeper cleaning.

I understand that my gums will be checked for gum disease. The type of cleaning that I can receive is determined by this examination, it is a clinical decision only. All findings will be explained to me, as well as recommended treatment and any costs associated with it. I understand that if I have gum disease, I cannot receive a prophylactic cleaning in this office, to do so would go against our medico-legal obligation to our patients as well as our ethical comfort zone. (My signature does not acknowledge my consent to services or fees)

Name _____

Date_____

FINANCIAL POLICY

My signature below shall serve as my authorization to assign any dental benefits paid by any third-party insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered.

I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, coordination of benefit rules and information received from me. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility.

Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances.

As a courtesy, this office will prepare insurance forms and assist in making collections from insurance companies; however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account.

If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in advance.

Name:_____

Signature:_____

Date:_____

AD
Arcadia Dental

CONSENT FOR TREATMENT

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) listed in my treatment plan. I understand my dental condition and have discussed any available alternate treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I give my consent for the undersigned provider and any other qualified assistants or medical professionals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment.

I confirm that I understand this form and the information contained therein. I am fluent in English or have been offered the opportunity to discuss treatment in my native language.

Name:

Signature:

Date: