Amherst Dental Group LLP

PATIENT REGISTRATION

First Name: ______________________ Last Name: ______________________ Middle Initial _____

Patient Is: □ Policy Holder
□ Responsible Party

Preferred Name: ______________________

Responsible Party (If someone other than the patient)

First Name: ______________________ Last Name: ______________________ Middle Initial _____
Address: ______________________ Address 2: ______________________
City, State, Zip: ______________________ Home Phone: ______________________
Work Phone: ______________________ Ext: ___________ Cellular: ______________________
Birth Date: ______________________ Soc Sec: ______________________

○ Responsible Party is Also Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ______________________ Address 2: ______________________
City: ______________________ State, Zip: ______________________
Home Phone: ______________________ Work Phone: ______________________ Ext: _________ Cellular: ______________________
Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed
Birth Date: ______________________ Age: ______________________ Soc Sec: ______________________
Email: ______________________ □ I would like to receive correspondences via email

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
Medicaid ID: ________________ Pref. Dentist: ________________
Employer ID: ________________ Pref. Hygienist: ________________
Carrier ID: ________________ Pref. Pharmacy: ________________

Section 3

Emergency Contact: ______________________
Contact's Phone: ______________________
Other Address: ______________________
Other Address 2: ______________________
Physician: ______________________
Physician #: ______________________

Primary Insurance Information

Name of insured: ______________________ Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec: ______________________ Insured Birth Date: ______________________
Employer: ______________________
Address: ______________________
Address 2: ______________________
City, State, Zip: ______________________
Rem. Benefits: ________________ Rem. Deductible: ____________

Insurance Company: ______________________
Address: ______________________
Address 2: ______________________
City: ______________________
State, Zip: ______________________

Secondary Insurance Information

Name of insured: ______________________ Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec: ______________________ Insured Birth Date: ______________________
Employer: ______________________
Address: ______________________
Address 2: ______________________
City, State, Zip: ______________________
Rem. Benefits: ________________ Rem. Deductible: ____________

Insurance Company: ______________________
Address: ______________________
Address 2: ______________________
City: ______________________
State, Zip: ______________________

Amherst Dental Group LLP

MEDICAL HISTORY

NAME: ______________________________ DATE: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for your answers to the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ○ Yes ○ No ______________________

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ______________________

Are you on a special diet? ○ Yes ○ No ______________________

Do you use tobacco? ○ Yes ○ No

Do you use 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 □ Local Anesthetics

□ Other If yes, please explain: ______________________

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

□ AIDS/HIV Positive
□ Alzheimer's Disease
□ Anaphylaxis
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Cold Sores/Fever Blisters
□ Congenial Heart Disorder
□ Convulsions
□ Cortisone Medicine
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/ Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Genital Herpes
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Murmur
□ Heart Pace Maker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: ______________________

Comments:

____

____

____

____

____

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 ______________________ DATE ______________

Amherst Dental Group LLP

DENTAL QUESTIONAIRE

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

Approximate date that you were last seen by a dentist: ____________________ Reason: _________________________

1. Are you having discomfort at this time? -- Y / N

Please check if you are having any of the following concerns with your **teeth**:	
Sensitive to hot	
Sensitive to cold	
Sensitive to sweets	
Sensitive to biting	
Pain upon biting or chewing	
Food impaction or food catch	
Teeth or fillings breaking	
Change or concern with how teeth come together when biting or chewing	
Visible stains / discoloration	
Cosmetic concerns with the appearance of your teeth	

Please check if you have any of the following concerns in your **mouth**:	
Bleeding gums, either spontaneously or while brushing or chewing	
Gums feel irritated, tender or swollen	
Tendency to chew on one side of mouth	
Unpleasant taste / bad breath	
Grinding or clenching of teeth during day or night	
Pain in face / neck muscles / ear/ jaw	
Swelling or lumps present	

2. Have you ever had any serious injury to your head or jaw? --- Y / N
3. Do you avoid any part of your mouth when you brush? -- Y / N

Please check if you use the following:			
Manual toothbrush		Dental floss	
Electric toothbrush		Mouthwash	
Fluoride rinse		Other (proxy brush, rubber tip, water pic, etc)	

4. Have you ever lost any of your teeth (excluding baby teeth)? --- Y / N
5. Have you ever had any problems with extractions? --- Y / N
6. Have you ever had any special dental work done (i.e braces, periodontal surgery, etc)? ------------------- Y / N
7. Have you had any bad dental experiences in the past? -- Y / N
8. Do you have any other questions or comments?

____

____

____

____

____

Amherst Dental Group
650 Main Street | Amherst , MA 01002 | (413) 253-9582

Written financial policy

Thank you for choosing Amherst Dental Group . Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Our office accepts:

- Cash or check, Visa®, MasterCard®, American Express® or Discover Card®

We offer our patients a 5% discount on services not covered by insurance if paid in full by cash, check, or card on or before the date of service.

a) · Special financing options with convenient monthly payments available with the -CareCredit healthcare credit card.

Please note: If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $35 is charged for patients who miss or cancel more than one time per calendar year without 24-hour notice. If the appointment is greater than 1 hour of time with the doctor then a fee of $100.00 will be charged for patients who do not give a 24 hour notice to reschedule

Our practice charges a $35 fee for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

____

_ *Patient, parent or guardian signature Date*

____

_ *Patient name (please print)*

[1] *Not including CareCredit.*

[2] *CareCredit is a credit card offered by Synchrony Bank and is NOT an in-house credit program offered by our practice. You may apply for the CareCredit healthcare credit card and if approved, use it at our practice. However, the CareCredit credit card agreement is between you and Synchrony Bank. Subject to credit approval.*

[3] *If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.*

Amherst Dental Group LLP

Patient Name: ____

PART I
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You may refuse to Sign This Acknowledgement

I have received or was offered a copy of this office's Notice of Privacy Practices. _______ (please initial)

PART II
AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

1. I, ________________________________, authorize Amherst Dental Group to use and/or disclose my protected health information for the purposes of treatment, payment and/or heath care operations to the person(s) listed below:

Name of Authorized Person: ____

Relationship to Self: ___________________________

Name of Authorized Person: ____

Relationship to Self: ___________________________

□Check this box if you do not authorize the use and/or disclosure of protected health information

2. I understand that this consent can be cancelled at any time and is optional. A signed consent can be delivered in person or mailed to the address listed above, and will become effective upon receipt.

3. I understand that disclosing information to someone who is not required to comply with the federal privacy protection regulations may result in re-disclosed information.

My signature certifies that I authorize Amherst Dental Group to disclose my health information to the above listed person(s) to the extent necessary to help with my healthcare or with payment for my healthcare.

X____
Signature Date

____
Print Name

Amherst Dental Group LLP

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the options of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the possibility of occurrence.

It is very important that you provide your dentist with accurate information (including changes in general health, medications, etc.) before, during, and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Dentistry is not an exact science. Although every effort will be made to optimize treatment results, reputable practitioners cannot properly guarantee results.

Please read the items below and sign at the bottom of the form.

1. **Treatment to be Provided**
   I understand that during my course of treatment the following care may be provided:
   - Examinations – including x-rays and intraoral pictures
   - Preventative services – including sealants and dental prophylaxis
   - Restorations – fillings, inlays, onlays, veneers
   - Crowns and bridges
   - Root Canal Therapy
   - Dental surgery procedures – incision and drainage, routine and surgical extractions
   - Removable appliances – flippers, occlusal guards, full and partial dentures
   - Restoration of dental implants
2. **Drugs and Medications**
   I understand that antibiotics, analgesics, antiseptics, local anesthetics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Local anesthetics can cause numbness or tingling of the lip, chin, face, mouth, teeth and tongue, and changes in taste sensation; which is usually temporary but in rare cases may be permanent.
3. **Treatment Complications**
   I understand that treatment complications may necessitate additional medical, dental, or surgical treatment; and may require additional periods of recuperation at home or in the hospital.
4. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
5. I give permission to the dental office to bill my insurance provider for the treatment provided, if applicable.

____ Patient Signature

___________________________ Date