Adult New Patient Form

Today's Date: _____

Patient Information

Patient Name (*First, Middle, Last*) _____DOB_____Gender_____

Preferred Name(s) (if any) _____Preferred Language_____

Marital Status _____Profession_____

Contact Information

Mailing Address_____City_____State_____Zip code_____

Cell phone:_____Home phone:_____Email_____

Emergency Contact Name: _____Phone:_____Relationship _____

Preferred Pharmacy: _____Phone Number_____

Dental Provider Previous Dental Provider (*if any*)_____

Insurance Information: (Please provide your insurance card so we can make a copy)

Primary Insurance: Insurance Subscriber (*full name*) _____DOB _____

Relationship to Subscriber: Self / Child / Spouse / Other Employer (if employer plan)_____

Insurance Company_____

ID#_____ Grp # _____

Secondary Insurance: Insurance Subscriber (*full name*) _____DOB _____

Relationship to Subscriber: Self / Child / Spouse / Other Employer (if employer plan)_____

Insurance Company_____

ID#_____ Grp # _____

Responsible Party Signature_____Date_____

If minor under age 18, parent/guardian must sign. Print Name of Guardian: _____

How did you hear about us?

- ❑ Existing patient
  Please tell us who so we can thank them through our referral program! _____
- ❑ Word of mouth
- ❑ Drive By/Saw Sign
- ❑ Facebook
- ❑ Instagram
- ❑ Google search
- ❑ Newspaper
- ❑ Mailer
- ❑ Referred from doctor _____
- ❑ Other _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus)___	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates)_____	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)_____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)_____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Financial & Appointment Policy

We are privileged that you have chosen us as your dental provider! We are committed to providing you and your family with the best quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to the commencement of dental care in our office. Here at Restoration Smiles, it is our main priority to provide you with the highest quality of care and we do not allow insurance companies or finances to compromise our treatment recommendations. We will always make recommendations on what is considered the highest standard of care and what will provide you with the best possible outcome, not by what insurance covers. However, we understand that dental care can be costly and we are happy to help mitigate the financial burden by accepting most insurance plans, offering financing options, and also an in-office membership savings plan. If your insurance changes or updates, please contact us as soon as possible to provide your new insurance information.

Regarding Insurance

Your insurance policy is a contract between **you** and **your insurance company**. **We have no control over their decisions and the amount they decide to pay**. However, as a courtesy to our patients, we will file your primary insurance claims for you. Before treatment, we will do our best to verify your coverage and calculate your deductible and co-payments as accurately as possible. **Please understand that all treatment plans given are only an estimate based on the information your insurance company provides to us**. All estimated deductibles and co-payments are due the day treatment is rendered. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL**. Once a payment is received on your claim, we will send you a statement of balance due by text, email or mail if there is a outstanding balance on your account. If you believe the insurance company has not provided an accurate payment it is your responsibility to contact your insurance company to resolve the issue.

Any unpaid balance after 90 days will be sent to collections at which time the patient is responsible for any fees associated with the collection of the balance. I understand that should my account become delinquent, I will be legally responsible for all costs involved with the collection of this account including collection fees and attorney fees.

Regarding Payments and Booking of Procedures

FULL PAYMENT OF YOUR ESTIMATED PORTION IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and most major credit cards (Visa, Mastercard, Discover). There will be a $50.00 fee on all returned checks. We require a deposit of $100-200 to book a complex restorative appointment of 1.5 hours or longer, depending on the type of treatment. If you require an appointment of this length for restorations, crowns, smile design, whitening, etc., we require a $100-200 non-refundable deposit which can only be applied to the planned treatment for that day. If you miss or cancel this appointment without 48 business hour notice a $50 missed/canceled appointment fee will be assessed.

Regarding Missed/Canceled/Rescheduled Appointments

We understand that there are times when you must miss an appointment due to illness, emergencies, or obligations for work or family matters. To provide the highest quality care and service to our patients, **we**

ask that you notify us 48 business hours in advance to cancel and/or reschedule your reserved appointment. When you cancel an appointment with less than 48 business-hour notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

We require confirmation for all appointments. As a courtesy to you we employ the use of a confirmation service to improve the efficiency of your ability to **confirm your appointment by email, text message, or phone call.** This system was implemented to limit the amount of last-minute cancelation/missed appointments due to the high demand for dental care. If you do not confirm your appointment 48 business-hours prior, we may cancel your appointment and offer it to another patient in need. **Monday appointments are highly desired and must be confirmed by the preceding Thursday.**

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliance are not only very much appreciated but will help us to help you achieve a positive outcome.

Regarding Late Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.** Thank you in advance for your cooperation. Your cooperation enables us to serve the needs of all our patients.

By signing below, I understand and agree to the following terms and conditions set forth in this financial agreement. Please **initial** and sign below:

_____* I understand that full payment of my estimated portion is due at the time of service.

_____* I am aware that if a balance remains after insurance payment, my statements will be sent electronically. At any time, I can verify with office staff if I have any questions regarding a sent statement.

_____*If I cancel and/or reschedule an appointment within 48 business hours of my appointment, this will result in a ($50) fee automatically applied per canceled patient appointment. I understand this will not be covered by my insurance company.

_____*After my family has had three missed appointments/late cancellations, Restoration Smiles, P.C. reserves the right to only offer my family same-day appointments or dismiss my family from the care of Restoration Smiles, P.C.

_____

Patient Name

_____ _____ _____

Patient/Guardian Signature Patient/Guardian Print Name Date

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to the individuals indicated below. I authorize Restoration Smiles to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of Restoration Smiles to communicate by leaving voicemail, texts or sending an email. Sometimes it may be easier to communicate about treatment needs, answer billing questions, or address a specific concern by leaving a detailed voicemail message or email, if the phone call is not answered by the recipient. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages. Please mark your preference below:

_____ I authorize Restoration Smiles to leave detailed voicemails/texts/emails on the phone number(s)/email(s) provided on my New Patient Paperwork.

_____ I DO NOT want any **detailed messages** left on my voicemail or sent via email. I understand that Restoration Smiles will still leave voicemail, text, email messages about appointment reminders and I can opt out of ANY automatic text messages and emails by replying STOP to the message received.

I understand I have the right to revoke this authorization at any time in writing. I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

Signature:_____Date:_____

Restoration Smiles Adult & Pediatric Dentistry
2 Coolidge Street Suite 202 Hudson MA
P/F: 508-658-0661

The Office of Dr. Divy Soni & Dr. Veronica Mitko

Today's Date: _____

Name (Please print)_____
(Patient Name/Guardian Name (If patient is a minor)

Release of Information to Insurers and Assignment of Benefits
(must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: _____
(If patient is a minor, parent/guardian must sign)

Notice of Privacy Practices (HIPAA) (must be signed by ALL new patients)

By signing below, I acknowledge that I have received and read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____
(If patient is a minor, parent/guardian must sign.)

Financial & Appointment Policy (must be signed by ALL new patients)

By signing below, I acknowledge that I received and read the Financial & Appointment Policy and agree to abide by such policies.

Signature: _____
(If patient is a minor, parent/guardian must sign.)

General Consent to Treatment (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the General consent to treatment form, understand the benefits and risks of dental treatment and authorize the necessary dental treatment

Signature: _____
(If patient is a minor, parent/guardian must sign.)

Please let us know if you would like an additional hard copy of any of our policies. You can also find them conveniently located on our website for your reference.