PATIENT REGISTRATION

ID: _____ Chart ID: _____

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: _____ Age: _____ Soc Sec: _____ Driver's Lic: _____

❑ Responsible Party is also a Party 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: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Driver's Lic: _____

E-mail: _____ ❑ I would like to receive correspondence via e-mail.

❑ I would like to receive correspondence via text message.

SECTION 2

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired

Student Status: ❑ Full Time ❑ Part Time

Medicaid ID: _____ Pref Dentist: _____

Employer ID: _____ Pref Pharmacy: _____

Carrier ID: _____ Pref Hyg.: _____

SECTION 3

Ins Group #: _____

Primary Insurance Information

Name of insured: _____ Relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of insured: _____ Relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

WM WEST MILL Smiles

Your Smile, Our Responsibility

2 West Mill Street • Medfield, MA 02052 • **Phone:** 508.359.8004 • **Fax:** 508.359.7443 • **www.WestMillSmiles.com**

MEDICAL HISTORY

PATIENT NAME: _____ Birth Date: _____

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

Name of primary physician: _____

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 If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ 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 ❑ Sulfa Drugs

❑ 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
❑ Congenital Heart Disorder
❑ Convulsions
❑ Coristone 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 Pacemaker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse
❑ Ostereoporosis
❑ 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
❑ 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: _____

WM WEST MILL Smiles
Your Smile, Our Responsibility

2 West Mill Street • Medfield, MA 02052 • **Phone:** 508.359.8004 • **Fax:** 508.359.7443 • **www.WestMillSmiles.com**

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) ___/___/___.
- ☐ Communications barriers prohibited obtaining an acknowledgment.
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other _____

Attempt was made by: _____ Date: ___/___/___

WEST MILL Smiles
Your Smile, Our Responsibility

Written Financial Policy

Thank you for choosing West Mill Smiles. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. In an effort to hold the line on dental costs while maintaining a superior level of professional care, we have established the following payment options:

- Payment in full at time of treatment
- Payment of the portion the insurance carrier will not cover (co-payment or deductible), on the day treatment is rendered
- Cash, check, Visa, Mastercard, Discover, or American Express
- Convenient Monthly Payment Plans from Care Credit and Springstone (*subject to credit approval)

Please note:

Our Financial Coordinator will help you with using our credit card service, or other financial arrangements when extensive dental care is necessary. On occasion we do offer in-office payment arrangements, evaluated on a case-by-case basis.

West Mill Smiles requires payment prior to the completion of your treatment. 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 will submit your claim to your carrier **as a courtesy**. We still require co-payment or deductibles at time of treatment for each claim. However, if we do not receive payment from your carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR INDIVIDUAL POLICY AND ITS COVERAGE.

A fee of $45.00 per half hour is charged for any failed appointment with the dentist without 48 hours advance cancellation notice. A fee of $75 is charged for every failed hygiene appointment without 48 hours advance cancellation notice. Reminder calls are a courtesy and not a requirement of the practice.

West Mill Smiles charges $25 for returned checks. Any account referred out to a collection agency requires the patient to reimburse West Mill Smiles the cost of such actions, should the patient request dental services to remain with West Mill Smiles. At such visits, balances will be due and payable at time of service. Accounts placed with a collection agency may adversely affect your credit report.

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

_____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

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 option 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 slights the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you 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 or your dentist, you may increase the chances of a poor outcome.

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

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

- Examinations
- Preventative Services
- Restorations
- Crowns
- Bridges
- Other

Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials _____

WEST MILL Smiles
Your Smile, Our Responsibility

3. 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.

Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Initials _____

5. I understand that if I refuse to have an intial comprehensive exam I will be released from the practice.

_____ _____

Patient Signature **Date**

_____ _____

Office Signature **Date**

Do you have a Great Smile?

Smile Assessment

Yes	No	
❑	❑	Are you comfortable showing your teeth when you smile?
❑	❑	Are you happy with the appearance of your teeth?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Are your teeth sensitive to hot or cold?
❑	❑	Do you feel your teeth are too long?
❑	❑	Do you feel your teeth are too short?
❑	❑	Do you like the color of your teeth?
❑	❑	Are you missing teeth?
❑	❑	Are you interested in improving the appearance of your teeth?
❑	❑	Are you interested in tooth replacements?
❑	❑	Are you familiar with the benefits of dental implants?
❑	❑	Are your gums sensitive?
❑	❑	Do your teeth or gums hurt?
❑	❑	Are your gums receding?
❑	❑	Are you anxious or fearful of treatment?
❑	❑	Are you interested in esthetic (cosmetic) dentistry?

Please feel free to explain any answers.

_____

_____

_____

WM WEST MILL Smiles

Your Smile, Our Responsibility

Dr. Jennifer Lee • 2 West Mill Street • Medfield, MA 02052
Phone: 508.359.8004 • **Fax:** 508.359.7443 • **www.WestMillSmiles.com**