NCDC
Newton Corner
DENTAL CARE

General Consent

I, _____ (print name), consent to be a patient at Newton Corner Dental Care and agree to a radiographic and clinical examination. I also understand and consent to the following:

- During the course of treatment, I may elect to undergo procedures in all phases of dentistry including periodontics (gum therapy), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, preventative therapy, orthodontics, temporomandibular disorder treatment, oral pathology, pediatric dentistry and radiography.

- I will provide a thorough and complete medical history, supply a full list of my medications, and consent to my dentist communicating with my other medical practitioners to inquire about any relevant aspect of my health history.

- No guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

- I understand and I have the right to accept or reject recommended dental treatment, and that if is my responsibility to consider the anticipated benefits, commonly known risks of the recommended procedure, alternative treatment, or the option of no treatment.

- My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

- I am welcome to ask questions about any aspect of my dental care and will request information if I lack full understanding or need more information. I am responsible for clarifying any aspect of my treatment that I am unsure about.

- I understand that payment or the establishment of financial arrangements is required before services are rendered, and I will pay in full any cost of treatment or insurance co-payment accordingly. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved by my insurance provider, I am responsible for any costs that my insurance does not cover. I acknowledge that this dental office, like any other, has limited access to information regarding my insurance benefits, and, as such I am ultimately responsible for understanding how my unique insurance benefits may reimburse the cost of my care.

- I agree to make my best effort to keep all scheduled appointments, and I understand that this office requires a 24-hour notice for any appointment cancellation or appointment change. I understand that a $75 fee will be charged for any missed appointment or appointments canceled with less than a 24-hour notice.

Signature Date

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Medical History

Name: Last, First, MI _____

Have you ever had any of the following medical conditions?

❑ Aids/HIV Positive	❑ Heart Disease	❑ Dry Mouth/Xerostomia	❑ Fainting	❑ Heart Valve repair/replace
❑ Alcohol Use	❑ Heart Murmur	❑ Recreational Drug Use	❑ Gag Reflex	❑ Visually Impaired
❑ Anemia	❑ TIA	❑ Renal Dialysis	❑ Glaucoma	❑ Venereal Disease
❑ Arthritis	❑ Hemophilia	❑ Respiratory Problems	❑ Hay Fever	❑ Ulcers
❑ Artificial Joints	❑ Hepatitis	❑ Rheumatism	❑ Head Injuries	❑ Tumors or Growths
❑ Aspirin Use	❑ Herpes Simplex	❑ Seasonal Allergies	❑ Hearing Impaired	❑ Tuberculosis
❑ Asthma	❑ High Blood Pressure	❑ Seizures	❑ Mental Disorders	❑ Lyme Disease
❑ Blood Disease	❑ High Cholesterol	❑ Sinus Problems	❑ Multiple Sclerosis	❑ Low Blood Pressure
❑ Blood Thinner	❑ Irregular Heartbeat	❑ Sleep Apnea	❑ Osteoporosis	❑ Excessive Bleeding
❑ Cancer	❑ Jaundice	❑ Stomach Problems	❑ Pacemaker	❑ Tobacco Use
❑ Diabetes	❑ Kidney Disease	❑ Stroke	❑ Parkinson Disease	❑ Thyroid Disease
❑ Dizziness	❑ Liver Disease	❑ Swollen Glands	❑ Radiation Treatment	

Do you have any other health concerns not listed above? ❑ Yes ❑ No

If Yes, please explain: _____

Please list any medications, pills or drugs you are currently taking: _____

_____

Are you allergic to any of the following? ❑ Food Dye ❑ Latex ❑ Aspirin ❑ Ibuprofen ❑ Mint Polish ❑ Sulfate ❑ Codeine ❑ Metal
❑ Peanuts/Nuts ❑ Acetaminophen ❑ Epinephrine ❑ Fruit ❑ Sodium Laureth ❑ Penicillin ❑ Sulfa Drugs ❑ Local/Topical Anesthetic

Do you have any other Allergies not listed above? ❑ Yes ❑ No

If Yes, please explain: _____

Are you taking or have you ever taken medications for osteoporosis? ❑ Yes ❑ No

Do you have a physician (medical doctor)? ❑ Yes ❑ No Doctors Name: _____

Have you been hospitalized or had a major surgery? ❑ Yes ❑ No Please Explain:_____

Do you use tobacco products? ❑ Yes ❑ No Do you use controlled substances? ❑ Yes ❑ No

Women: Are you pregnant or think you are pregnant? ❑ Yes ❑ No Women: Are you nursing? ❑ Yes ❑ No

Is there any other information we should know? ❑ Yes ❑ No

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature Date

NCDC
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DENTAL CARE

Name: Last, First, MI: _____ *Date of Birth:* _____

Social Security Number: _____ *Drivers License Number:* _____

Gender: ❑ Male ❑ Female *Family Status (insurance purposes):* ❑ Single ❑ Married ❑ Divorced

Student Status: ❑ Student ❑ Non Student

Address: _____

City/State/Zip: _____

Home Phone: _____ Email: _____

Mobile Phone: _____ May we send appointment reminders to your Email? Y/N

Work Phone: _____ May we send appointment reminders to your mobile via Text? Y/N

Emergency Contact: _____ Emergency Phone #: _____

Dental History

How did you hear about our Office? _____

How long has it been since your last visit to the dentist? _____

Why are you changing dentists? _____

Name of previous dentist: _____

Reason for Today's Visit: ❑ Check up ❑ Cosmetic Concern ❑ Pain / Discomfort ❑ Other: _____

Have you ever had a bad experience at the Dentist?	❑ Yes	❑ No
Have you had any complications following dental treatment?	❑ Yes	❑ No
Have you had an unfavorable reaction to dental anesthetic?	❑ Yes	❑ No
Does dental treatment make you nervous?	❑ Yes	❑ No
Are your teeth sensitive to hot/cold?	❑ Yes	❑ No
Do your gums bleed when you brush or floss?	❑ Yes	❑ No
Do you clench or grind your teeth?	❑ Yes	❑ No
Are you aware of sores or irritated areas in the mouth?	❑ Yes	❑ No
Have you ever been treated for Periodontal Disease?	❑ Yes	❑ No

How often do you brush? _____

How often do you floss? _____

Do you like your smile? _____

If you could change your smile, what would you like to change?

❑ Change the color of my teeth ❑ Change the shape of my teeth ❑ Nothing - I am happy with my smile

❑ Change the position/alignment ❑ Restore worn/broken teeth ❑ Other

I am interested in:

❑ Routine, Preventive Care ❑ Replacement of missing teeth ❑ Teeth Whitening

❑ Teeth Straightening ❑ Other

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.

Patient/Guardian Signature Date

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Notice of Privacy Practices Acknowledgement

I, _____ (print name), acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. I understand that I may refuse to sign this acknowledgement.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

I authorize the following individuals (example; spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care, and that if no individuals are listed, we will NOT share any information regarding your account.

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

I authorize information about my health to be communicated to me via:

❏ All of the following are acceptable
❏ Text message to my cell phone
❏ Email confirmation
❏ Cell phone confirmation
❏ Home phone confirmation
❏ Work phone confirmation

In signing this HIPAA Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

Signature *Date*

For Office Use Only

As Privacy Officer, I attempted to obtain patient's (or representative's) written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Privacy Officer Name / Date: _____