West Roxbury Smiles
Pediatric Dentistry • Orthodontics

ADULT PATIENT HISTORY

Thank you for selecting our dental team! To help us meet all your health/dental needs, please fully complete this form. If you have any questions, concerns or need assistance, we will be happy to help.

First Middle Last / /
Name Birthdate

Address City Zip

Birthdate / / Email Please provide the email you check the most ☐ Male ☐ Female

Home ( ) Work ( ) Cell ( )

Employer's name

Employer's address City Zip

Emergency Contact Please provide a friend/relativecontact we can reach in case of emergency (and we cannot cannot reach you at the numbers or email address you provided above):

Name Home ( ) Cell ( )

Whom can we thank for referring you to our practice?

Responsible Party for this Account First name Last name

Please provide the email checked during a business week
Relationship to the adult patient Email of responsible party for this account

Home ( ) Cell ( ) Work ( )

Employer

Employer's address City Zip

Methods of Payment For your convenience, we offer the following methods of payment. Please check the option you prefer for payment in full at each appointment:

☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ AmEx ☐ Discover

Dental Insurance Information

Name of insured Relationship to patient

/ / - - / /
Birth date SS# Date of employment

Employer Work ( )

Employer's address City Zip

Dental insurance company Group # Policy ID #

Insurance company address City Zip

How much is your deductible? $_____ How much have you used? $_____

What is the maximum annual benefit? $_____ Do you have additional dental insurance? ☐ Yes ☐ No

If 'yes', please complete the following Additional Dental Insurance Coverage information:

Name of insured Relationship to patient

Birth date SS# Date of employment

Employer Work ( )

Employer's address City Zip

Dental insurance company Group # Policy ID #

Insurance company address City Zip

How much is your deductible? $_____ How much have you used? $_____

What is the maximum annual benefit? $_____

Medical Health History

First name Last name ( )

Primary Care Physician's name City Office

_____/___/_____ Are you under medical care now? ☐ Yes ☐ No

Date of your last full physical exam

If 'yes', please explain: _____

Have you been hospitalized within the last five (5) years? ☐ Yes ☐ No If 'yes', please explain:

Are you taking any medications or prescriptions at this time? ☐ Yes ☐ No If 'yes', please list:

Do you take any vitamins or supplements on a regular basis? ☐ Yes ☐ No

If 'yes', please list: _____

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How much fluoridated water do you drink daily? ☐ 2-4 cups ☐ 5-8 cups

What do you drink on a regular basis besides water? _____

Do you drink diet soda or beverages containing artificial sweeteners on a regular basis? ☐ Yes ☐ No

Do you smoke or use tobacco of any kind? ☐ Yes ☐ No

Allergy History

☐ Local anesthetics (Novocain) ☐ Iodine ☐ Aspirin ☐ Penicillin
☐ Tylenol liquid containing red dye) ☐ Any metals (nickel, mercury, etc.) ☐ Latex products
☐ Sulfa drugs ☐ Other _____

Do you have a history of (or have you *ever* had a history of) any of the following:

☐ Heart murmur
☐ Mitral valve prolapse
☐ Diabetes
☐ Asthma
☐ Epilepsy/Convulsions
☐ Headaches/migraines
☐ Stomach troubles
☐ Blood disorders
☐ AIDS or HIV
☐ Cerebral damage
☐ Down's syndrome
☐ High blood pressure
☐ Heart condition of any kind
☐ Seasonal allergies
☐ Tuberculosis
☐ Neurological problems
☐ Hepatitis/jaundice
☐ Diarrhea/constipation issues
☐ Kidney disease
☐ Abnormal bruising/bleeding
☐ Chicken pox
☐ Hyperactivity/ADD/ADHD
☐ Low blood pressure
☐ Rheumatic fever
☐ Respiratory problems
☐ Fainting/seizures
☐ Multiple chemical sensitivities
☐ Liver disease
☐ Anemia
☐ Eye problems
☐ Autism
☐ Depression
☐ Cancer/Tumors

Do you have any dental anxiety about seeing us today? ☐ Yes ☐ No

Are you up-to-date with your immunizations? ☐ Yes ☐ No

Dental health history and habits

☐ Injuries to the mouth/teeth/head
☐ Thumbsucking
☐ Fingersucking
☐ Brush your teeth 2-3 times daily
☐ Tongue and/or lip pierced
☐ Grinding of teeth during the day or while asleep
☐ Fluoride used/taken in any form
☐ Swollen gums/painful gums
☐ Snoring
☐ Clicking or popping of jaw
☐ Cavities
☐ Toothache(s)
☐ Nailbiting
☐ Unusual speech habits
☐ Bad breath
☐ Mouthbreathing
☐ Crooked teeth
☐ Discolored teeth, some or all
☐ Do you floss your teeth daily?

How long ago was your last visit to a dentist? ____/____/____

Are there any other dental problems or concerns today? _____

First name Last name City ( )

Name of previous dentist (or orthodontist)

Purpose of today's appointment is _____

Thank you for your help in giving us the information we need in this form to best serve your dental and/or orthodontic needs/concerns. If you feel there is ***any*** information that you think might be of value to us in treating you, your please feel free to note these details: _____

_____

Authorization and Release I certify that I have read and understand the information in this document to the best of my knowledge. The questions contained in this form have been accurately answered and I understand that providing incorrect information could be dangerous to my health. I authorize the treating professionals at West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics to release any information (including but not limited to the diagnosis and records for any treatment or examination) rendered to me during the period of such dental care to third-party payers and/or health practitioners.

_____ _____

Signature of patient Date of Signature

Patient Acknowledgement and Agreement I acknowledge that I have read this and fully understand the patient consent and possible future use of electronic mail (email) in sending communications back and forth between patient and the professional staff at West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics as well as email between providers and me and I consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that West Roxbury Pediatric Dentistry and Orthodontics and/or my dental insurance provider may impose to communicate with patients by email. Any questions on these communications I had have been answered.

_____ _____

Signature of patient Date of Signature

Statement of Receipt of Privacy Practices I have been provided with West Roxbury Smiles/West Roxbury Pediatric Dental and Orthodontics' Notice of Privacy Practices policy and by signing below I acknowledge receipt of this Policy. This Notice provides me with information about how West Roxbury Smiles/West Roxbury Pediatric Dental and Orthodontics may use and/or disclose my protected health information. I fu rther understand and accept that West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics' Notice of Privacy Practices is subject to change. If it sh ould change, I can obtain a copy of the revisions by contacting the practice at 617-327-4321 or emailing westroxburydental@yahoo.com. I acknowledge receipt of the Notice of Privacy Practices for the dental practice of West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics and all its dental professionals and providers.

_____ _____

Signature of patient Date of Signature

Statement of Financial Responsibility I authorize and request that my dental insurance company pay benefits directly to me. I further understand that my dental insurance carrier may pay less than the actual bill for services incurred with West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics and I agree to be responsible for payment of all services rendered on my behalf. In the case of a possible divorce, payment is expected from me, the patient. Any further payment arrangements must be worked out by me with my spouse, not involving West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics in any possible dispute(s) that may arise. I agree to assign benefits to the provider should a dental claim be filed. Insurance is filed as a courtesy and I understand that regardless of insurance coverage, the balance of this account is my responsibility I further understand that my appointments are confirmed within 24-48 hours prior to my scheduled time via telephone and/or email contact to the numbers/email address(es) that I have provided to West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics. If I have a scheduled dental hygienist appointment to have my teeth cleaned I will receive a postcard by U.S. Mail within 1-2 weeks of my appointment. If I need to change said appointment time I must provide at least 24 hours' notice so another patient may have my appointment time. If I do not show up for a scheduled appointment (or I give insufficient notice so another patient can be convenienced) I understand and accept that a $75.00/per hour fee may be charged to me. Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice without refund.

_____ _____

Signature of patient initiating consultation or services Date of Signature

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