BOSTON PROSTHODONTICS

Patient Information

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____ ☐ Male ☐ Female

☐ Single ☐ Married Birthdate: _____ Social Security #: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____ Email: _____

Employer: _____ Business phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

Where do you prefer to be contacted? ☐ Home ☐ Cellular ☐ Business ☐ Email

DENTAL INSURANCE INFORMATION

Name of insured person: _____ Relationship to patient: _____

Employer: _____ Birthdate of insured: _____ /_____ /_____

Insurance Co. name: _____ Subscriber ID: _____ Group #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip: _____

ADDITIONAL DENTAL INSURANCE INFORMATION

Name of insured person: _____ Relationship to patient: _____

Employer: _____ Birthdate of insured: _____ /_____ /_____

Insurance Co. name: _____ Phone: _____ Group #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY

Name of person responsible for payment: _____ Relationship to patient: _____

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Is the person responsible for payment currently a patient in our office? Yes ❑ No ❑

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____ Email: _____

Employer: _____ Business phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

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Health History

Patient name: _____ Birthdate: _____

Physician name: _____ Physician phone: _____

Do you take any medications?

Yes ❑ **No** ❑ If yes, please list all medications and the reason why you are taking them.

_____

_____

Do you smoke cigarettes or use smokeless tobacco? Yes ❑ **No** ❑

Have you ever taken oral or intravenous bisphosphonate drugs for osteoporosis, metastatic cancer, or other conditions?
Examples of bisphosphonates are alendronate (Fosamax®), risedronate (Actonel®), pamidronate (Aredia®) and zoledronate (Zometa®).
Yes ❑ **No** ❑

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Other allergies (If yes, please explain)
❑	❑	Local anesthetics	❑	❑	Latex			_____

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

Yes	No		Yes	No	
❑	❑	Alcohol or drug addiction	❑	❑	High blood pressure
❑	❑	Anemia	❑	❑	HIV or AIDS
❑	❑	Artificial joint replacement (hip, knee, etc.)	❑	❑	Kidney problems
❑	❑	Artificial heart valve	❑	❑	Liver problems
❑	❑	Asthma	❑	❑	Lung problems
❑	❑	Cancer	❑	❑	Psychiatric care
❑	❑	Congenital heart defect	❑	❑	Respiratory problems
❑	❑	Corticosteroid treatment	❑	❑	Radiation treatment
❑	❑	Dental phobia or anxiety	❑	❑	Rheumatic fever
❑	❑	Diabetes	❑	❑	Sinus problems
❑	❑	Endocarditis	❑	❑	Stomach or intestinal problems
❑	❑	Epilepsy or seizures	❑	❑	Stroke
❑	❑	Excessive bleeding	❑	❑	Thyroid problems
❑	❑	Fainting spells or dizziness	❑	❑	Tuberculosis
❑	❑	Heart pacemaker	❑	❑	Tumors or growths
❑	❑	Heart attack or heart problems	❑	❑	Other health problems
❑	❑	Hepatitis	❑	❑	If female, are you pregnant?
❑	❑	Herpes or cold sores	❑	❑	If female, do you take birth control pills?

Please provide additional information for all "yes" responses:

_____

_____

Signature: _____ Date: _____

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Dental History

Patient name: _____

What is the reason for your dental visit today? _____

_____

Do you currently have any teeth that are sensitive?

Yes ❑ **No** ❑ If yes, please explain. _____

_____

_____

When was the last time you saw a dentist? _____

When was your last professional cleaning? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

	Yes	No
Have you ever been treated for periodontal disease (gum disease)?	❑	❑
Do you feel that you can chew well with your teeth?	❑	❑
Do you grind or clench your teeth?	❑	❑
Do you ever have jaw pain or jaw muscle soreness?	❑	❑
Have you ever worn a nightguard or been told that you should?	❑	❑
Do you like the way your smile looks?	❑	❑
Do you like the color of your teeth?	❑	❑
Do you have any teeth or restorations that you are unhappy with?	❑	❑
Would you like to discuss esthetic improvements that can be made to your smile?	❑	❑

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50 STANIFORD STREET • BOSTON MASSACHUSETTS 02114 • 617 523 5451

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: _____

Signature: _____

Date: _____

*Complete Privacy Policy available upon request.