Welcome to our practice!

Thank you for selecting our team for your dental needs. We strive to provide you with the best possible dental care while making your visit with us as pleasant as possible. The benefits of a healthy and happy smile are immeasurable, and we look forward to working with you to meet all of your dental healthcare needs.

Patient Information

Todays date:_____

Full name: _____ Preferred name and/or pronouns: _____

Address:_____ City: _____State:_____Zip Code: _____ ___

Sex: ☐ M ☐ F ☐ Other _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnered

Date of Birth: _____ Age: _____ How did you hear about our office: _____

Cell phone: (_____)_____Home phone(_____)_____Work phone(_____)_____

Email address: _____ Social Security Number:_____

Occupation:_____ Place of employment:_____ _____

Spouse/Emergency Contact Information

Name: _____ Relation:_____ Sex: _____ Date of Birth: _____

Address:_____ City: _____State:_____ Zip Code: _____

Cell phone: (_____)_____Home phone(_____)_____Work phone(_____)_____

Dental Insurance Information

Subscriber Name: _____ Relation: _____ Sex: _____

Date of Birth: _____ Social Security: _____ Phone: (_____)_____

Address if different :_____ City: _____State:____ Zip: _____

Employer:_____Occupation: _____

Insurance company name: _____ Insurance company phone: (_____)_____

Subscriber ID: _____ Group Number: _____ Other numbers: _____

Secondary Dental Insurance Information (if applicable)

Subscriber Name: _____ Relation: _____ Sex: _____

Date of Birth: _____ Social Security: _____ Phone: (_____)_____

Address if different :_____ City: _____State:____ Zip: _____

Employer:_____Occupation: _____

Insurance company name: _____ Insurance company phone: (_____)_____

Subscriber ID: _____ Group Number: _____ Other numbers: _____

Appointment Confirmation Preferences

We send appointment confirmations through email and text. Please select one or both. If you would prefer a phone call instead, or to not receive confirmations, please let us know. ☐ Text ☐ Email

PLEASE CONTINUE ON NEXT PAGE

Medical History

Physician name:_____ Location:_____

Physician phone number: (_____)_____ Date of last exam:_____

Please list any serious illnesses or injuries that you've been hospitalized for in the past five years: _____

_____

Please list any medications (over the counter, prescription, or supplement) that you are taking and reason:

Medication (if more space is needed, please attach)	Reason medication or supplement is being used
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking birth control pills? ☐ Yes ☐ No ☐ Not applicable

Are you pregnant? ☐ Yes ☐ No ☐ Not applicable Are you nursing? ☐ Yes ☐ No ☐ Not applicable

Have you ever taken osteoporosis treatment drugs? ☐ Yes ☐ No

Have you ever taken or are you currently on blood thinners? ☐ Yes, in past ☐ Never ☐ Currently on since _____

Do you have any allergies to the following?

☐ Amoxicillin ☐ Aspirin ☐ Erythromycin ☐ Metals/Jewelry ☐ Sulfa ☐ Codeine

☐ Latex ☐ Penicillin ☐ Novocaine ☐ Epinephrine ☐ Tetracycline ☐ Other _____

If any items above are checked, please describe symptoms:_____

Do you snore or have you been told that you snore? ☐ Yes ☐ No Have you ever had a sleep study? ☐ Yes ☐ No

Any other medical issues we should be aware of? _____

Have you ever had or currently have any of the following:

☐ Alzheimers/Memory Loss	☐ Anemia	☐ Angina	☐ Arthritis
☐ Artificial heart valves	☐ Artificial hips or joints	☐ Asthma / Hay Fever	☐ Blood Transfusions
☐ Cancer/Chemotherapy	☐ Cold Sores/Herpes	☐ Congenital Heart Defect	☐ Diabetes
☐ Difficulty breathing	☐ Drug or Alcohol Abuse	☐ Emphysema	☐ Epilepsy/Seizures
☐ Fainting	☐ Gastrointestinal Disorder	☐ Glaucoma	☐ Headaches (frequent, severe)
☐ Hearing Impaired	☐ Heart attack	☐ Heart murmur	☐ Heart surgery
☐ Hemophilia (abnormal bleeding)	☐ Hepatitis A B C D	☐ High/Low Blood Pressure	☐ HIV+ / AIDS
☐ Liver Disease	☐ Kidney problems	☐ Migraines	☐ Mitral Valve Prolapse
☐ Pacemaker	☐ Radiation treatments	☐ Reflux	☐ Rheumatic/Scarlet Fever
☐ Shingles	☐ Smoking/Tobacco use	☐ Sinus Problems	☐ Stents in heart when:_____
☐ Stroke	☐ Depression	☐ Thyroid Problems	☐ Tuberculosis
☐ Tumor Growth	☐ Ulcers	☐ Venereal Disease	☐ Other _____

Would you like to speak privately with the doctor about any problems? ☐ Yes ☐ No

Premedication may be necessary if you have had any of the following:

° Prosthetic Cardiac Valve ° Previous bout of infective bacterial endocarditis ° Joint replacements
° Cardiac transplant patients who have had vulvulitis ° Congenital heart disease excluding mitral valve prolapse

I hereby certify that the information I have given here today is correct to the best of my knowledge:

Signature:_____ Date:_____

PLEASE CONTINUE ON NEXT PAGE

Dental History

Former Dentist name and phone: _____ Date of last dental care: _____

What type of treatment did you receive? ☐ Preventative ☐ Basic Fillings ☐ Major Restoration

Was that a comfortable experience? ☐ Yes ☐ No Why? _____

Why are you changing offices? ☐ Insurance ☐ Location ☐ Other _____

_____

Did you have any recommended treatment that was not completed? If yes, what? _____

Do you have any problems with your teeth now?

☐ Bad breath
☐ Bleeding Gums
☐ Broken tooth/teeth
☐ Clicking or pain in jaw
☐ Food collection between teeth
☐ Grinding/Clenching teeth
☐ Loose tooth/teeth
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity to biting
☐ Sores or growths
☐ Other _____

How often do you brush? _____ How often do you floss? _____ Do you use mouthwash? _____

Is there any bleeding when you brush or floss? _____ Are you concerned about bad breath or taste? _____

Dental Needs

What brings you to our office today? ☐ Exam/Cleaning ☐ Dental Problem ☐ Other _____

Are you happy with your smile? ☐ Yes ☐ No

What would you like to change if you could? ☐ Color ☐ Shape ☐ Position ☐ Straighter ☐ Replace missing teeth

Is there anything that you do not like about dental appointments? _____

Do you have any fears or anxieties about dental appointments? _____

Do you have any questions for the dentist or staff? _____

_____

What are the three most important ways that we as a team can make your experience the best possible?

1) _____

2) _____

3) _____

Authorization

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes to my medical status.
I authorize the dental staff to perform the necessary dental services that I may need. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
I understand that I am responsible for copayment at the time of service unless prior arrangements have been approved by the doctor or financial coordinator.

Printed name: _____ Date: _____

Signature: _____

PLEASE CONTINUE ON NEXT PAGE

Office Policies

Thank you for choosing Papageorgiou Dental Associates as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service possible.

Payment Policy

To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment.

Please indicate below your preferred method of payment:

_____ Cash _____ Check _____ Major Credit Card _____ Other

For patients with dental insurance:

- Dental insurance usually does not cover the total cost of your treatment.
- Based on your plan, we usually can estimate the amount of your copayment.
- Your estimated copayment is expected when treatment is performed.
- If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

*** For treatment amounts over $300, please inquire about the possibility of an extended payment plan. Our office offers 6 and 12 month interest-free plans through an outside financing company. If you are interested in this option, please inquire at the front desk. Financial arrangements must be made before treatment begins.

Acceptance Agreement: (please initial each line)

_____ I understand and agree to the above financial policy.
_____ I understand that as a parent/guardian/relative bringing a child for dental treatment, I am responsible for all fees incurred at that visit.
_____ I understand that I am responsible for all fees regardless of insurance coverage. I also understand that insurance companies make no guarantee of payment until a claim is processed even if a pretreatment estimate has been completed.
_____I understand that the copayments quoted in the office are estimated, and no certainties can be made as to their accuracy.

Cancelled or Broken Appointment Policy

We make every effort to be on time for our patients and ask that you extend the same courtesy to us.
We ask that if you cannot make your appointment with us, please call at least 48 hours in advance so that we may use that time that was reserved for you to help another patient in need of our services. In cases of inadequate notice or frequent broken appointments, we reserve the right to charge a fee based on the type of appointment that was missed.

Patient/Responsible Party:

Print name: _____

Signature: _____

Date: _____

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:

Papageorgiou Dental Associates
959 Worcester Street
Natick, MA 01760

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: ___/___/___