Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ [redacted] _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Medical History

Patient Name: Birth Date: Date Created:

Provider Signature

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.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

Patient Signature

Cape Cod Restorative Dentistry
General Consent Form

1. MEDICAL HISTORY AND MEDICATIONS INFORMATION
Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines/drugs that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any allergies you have.

2. X-RAYS AND PHOTOS
The initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

3. MEDICATION ADMINISTRATION
I have been informed and understand that anesthetics, analgesics and antibiotics and other medications used in dentistry, although rare, can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. Failure to take medications prescribed in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I have informed the Dentist of any known drug allergies.

4. RESTORATIONS
I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is common after the effect of newly placed fillings. In the case of a patient having deep decay near the tooth nerve, there is a high risk of developing sensitivity and the need for root canal treatment may arise. If this need occurs during the decay removal, the dentist will discuss further treatment options with the patient.

Initial: _____

5. DENTAL PROPHYLAXIS (CLEANING)
I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. In case of diagnosis of periodontal disease, the dentist will discuss further treatment options with the patient.

6. SPECIFIC PROBLEM EXAMINATION
In the event that a patient requests only a specific problem to be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. In this case the dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a comprehensive exam.

7. 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 teeth that could not be discovered during examination. A more extensive treatment plan than originally diagnosed and proposed may be required due to additional decay or unsupported tooth structure found during preparation of the tooth. This may lead to other measures necessary to restore the tooth to normal function including the need for root canal, crown, or both. I do authorize the performance of additional procedures and changes of planned procedures if, in the judgment of the doctor, this will be necessary to improve my safety and result. I give my permission.

8. COMPLICATIONS
Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent). Although extremely rare such conditions as Bell's Palsy and Trigeminal Neuralgia may occur due to use of injections and local anesthetics. Reaction to injections, changes in occlusion (bite), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure are a possible risks of any dental procedure.

Initial: _____

9. SPECIALTY REFERRAL AND/OR SECOND OPINION

General dentists perform the majority of all dental treatments today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

ACKNOWLEDGEMENT

I hereby authorize the dental staff of Cape Cod Restorative Dentistry to proceed with and perform dental treatments as explained to me above. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to allow staff of Cape Cod Restorative Dentistry to take x-rays and perform an examination on me today.

Initial: _____

Patient Name: _____

Patient Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your personal health information. Please sign this form to acknowledge your receipt of this notice. You may also refuse to sign this acknowledgement if you so wish.

_____

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

Print Name:_____
Signature:_____
Date:_____

__I authorize Cape Cod Restorative Dentistry to release any information pertaining to my treatment, dental appointments, and/or my dental account to my spouse, parent, guardian, child, caregiver or other person listed below:

Name of Person Authorized:_____
Patient Signature:_____
Date:_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

__The patient refused to sign.
__Due to an emergency situation it wasn't possible to obtain consent.
__We weren't able to communicate with the patient.
__Other (please provide specific details)

Employee Signature:_____ Date:_____

CAPE COD RESTORATIVE DENTISTRY FINANCIAL POLICY

We thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concern regarding our fees, policies, or responsibilities please feel free to contact Marie at 508-362-8188.

Please understand that payment for services is an important part of the provider-patient relationship. **If you do not have insurance, proof of insurance, or participate in a plan that will not honor us assignment of insurance benefits, payment of services will be due at the time of service unless a payment arrangement has been approved in advance by our staff**. We make payment as convenient as possible by accepting cash, MasterCard, Visa, AMEX, Discover and in-state checks). A $35.00 service fee will be charged for all returned checks.

Interest

Interest will incur if a balance remains unpaid after 60 days.

Insurance

Remember that your insurance policy is a contract between **you and your insurance carrier**. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges.

When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

We are happy to submit a pre-estimate or pre-authorization for treatment but as they state on the pre-estimate or pre-authorization itself, they are not a guarantee of payment.

Initial _____ Date_____

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reduction such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you, as the guarantor are responsible, for all out-of- network fees. If we are not contracted with your carrier, we cannot negotiate reduced fees with your carrier.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee may apply. These fees are typically $35.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointment without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying supplies, labor, and postage of the files, and summaries.

Overdue Payments

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know if ou require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Cape Cod Restorative Dentistry whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for cost of collection if such action becomes necessary.

Signature of Insured or Authorized Representative:

_____Date: _____