NCD
NEWTON CENTRE DENTAL
Advanced Aesthetic and Family Dentistry

1400 Centre Street Suite 201 Newton, MA 02459 (617) 965-2440 Fax (617) 965-2423

Date _____

Whom may we thank for this referral?

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City / State / Zip)

Home Phone _____/_____ Cell Phone _____/_____

Email Home _____ Email Work _____

Employer _____ Work Phone _____

Birthdate _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security No. _____ Occupation _____

If Minor, List Parents' Names Father _____ Mother _____

IF YOU WOULD LIKE US TO FILE INSURANCE CLAIMS ON YOUR BEHALF, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION. OTHERWISE, PAYMENT IS THE PATIENT'S RESPONSIBILITY ON THE DAY OF SERVICE. THANK YOU.

Dental Insurance Information (Please provide a copy of your Dental Insurance Card.)

Do you have Dental Insurance? ☐ YES ☐ NO Name of Insurance Company _____

Dental Insurance Company Address _____ (Street) _____ (City / State / Zip)

Name of Policy Holder _____ (Last) _____ (First) _____ (Middle)

Subscriber ID No. _____ Birthdate _____

Employer _____ Group No. _____

Employer Address _____ (Street) _____ (City / State / Zip)

Employer Phone _____/_____ Relationship to Patient _____

Emergency Information

Name _____ Relationship _____

Complete Address _____ (Street) _____ (City / State / Zip)

Home Phone _____ Work Phone _____

Getting to Know You

Is another member of your family a patient in our practice? Name _____

When was your last dental visit? _____ When was the last time you had complete dental X-rays? _____

Former Dentist: Name, Address, Phone _____

Why did you select our office? _____

We are all very pleased to meet you, and look forward to meeting your friends and family.

For All Patients _____ (SIGNATURE (Parent if minor)) _____ (Relationship) _____ (Date)

Continued

Medical History

Have you been under the care of a medical doctor during the past two years?_____ ☐ YES ☐ NO

Please explain _____

_____

Name of Physician _____ Phone Number _____

Physician's Address_____

Have you ever been hospitalized?_____ ☐ YES ☐ NO

Are you allergic to or made sick by ☐ penicillin ☐ aspirin ☐ codeine

☐ other Please list _____

Have you ever had excessive bleeding requiring special treatment?_____ ☐ YES ☐ NO

Check any of the following which you have had or have at present:

☐ Heart Disease or Attack	☐ Stroke	☐ Allergies or Hives
☐ Chest Pain	☐ Kidney Trouble	☐ HIV Positive
☐ Tuberculosis (TB)	☐ Ulcers	☐ Auto Immune Disease
☐ Asthma	☐ Shortness of Breath	☐ Diabetes
☐ Rheumatic Fever	☐ Emphysema	☐ Thyroid Disease
☐ Congenital Heart Lesions	☐ Common Cold	☐ Arthritis
☐ Artificial Heart Valve	☐ Hepatitis A	☐ High Blood Pressure
☐ Heart Pacemaker	☐ Hepatitis B	☐ Heart Murmur/Mitral Valve
☐ Heart Surgery	☐ Hepatitis C	☐ Hemophilia
☐ Artificial Joint	☐ Liver Disease	☐ Cold Sores or Fever Blisters
☐ Anemia	☐ Hay Fever	☐ Epilepsy or Seizures

Are you having dental problems at this time?_____ ☐ YES ☐ NO

If yes, please explain_____

Do you feel very nervous about having dental treatment?_____ ☐ YES ☐ NO

Do you take pre-medication before dental treatment?_____ ☐ YES ☐ NO

If yes, what do you take?_____

List all medications you are taking at this time. _____

_____

Are you a smoker?_____ ☐ YES ☐ NO

Do you have trouble getting numb for dental work?_____ ☐ YES ☐ NO

When you walk up stairs or take a walk, do you ever have to stop because

of pain in your chest, or shortness of breath or because you are very tired?_____ ☐ YES ☐ NO

Do your ankles swell during the day?_____ ☐ YES ☐ NO

Women: Are you pregnant? ☐ YES ☐ NO If yes, what month are you due? _____

Are you taking birth control pills?_____ ☐ YES ☐ NO

Do you have any disease, condition or problem not listed? If so, please list_____

- How do you feel about getting and maintaining a healthy mouth?_____
- How do you feel about the appearance of your teeth?_____
- If you could change anything about your smile, what would you change?_____

For Office Use Only: Updates (date and initial) _____ _____ _____ _____ _____ _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Run our practice, improve your care, and contact you when necessary

I have been informed by **NCD** of the Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that **NCD** has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ DOB: _____ /_____ /_____

Signature: _____

Relationship to Patient (if under 18): _____

Date: _____ / _____ / _____

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

(check one)

- ☐ Any member of my immediate family
- ☐ Spouse/Partner only
- ☐ Other (please specify) _____

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Appointment Cancellation Policy

Here at Newton Centre Dental we strive to render excellent dental care to all of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed without giving adequate notice, we may not be able to offer this time to another patient.

Our policy is as follows:

We require that you give our office a 24-hour notice in the event that you need to reschedule or cancel your appointment. If your appointment is scheduled on a Monday please let us know by noon the Friday before your appointment. This allows for other patients to be scheduled into that appointment time if necessary. If you missed an appointment without contacting our office or fail to do so within the required window of time, this is considered a missed appointment. A fee of $85.00 will be charge to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointment can be scheduled without the payment of this fee. If a second appointment is missed we will ask you to store a credit card on file so that we may charge it only in the event another one is cancelled without proper notice.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $85.00 cancellation fee will be applied to your account.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your support.

I have read and understand the Appointment Cancellation Policy of the practice and understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Newton Centre Dental Appointment Cancellation Policy.

_____

Signature of patient **Date**

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Payment Agreement Policy

Dear Valued Patient:

In an effort to provide our patients with flexible payment options, we have enclosed a list of payment types accepted here at Newton Centre Dental.

***All balances that are estimated by our office and/or dental insurance company are expected to be paid at the time of service. If you have any questions please don't hesitate to ask our front desk.**

Please select your preferred payment method.

For your convenience we accept the following forms of payment:

_____ **Payment by cash**

_____ **Payment by check**

_____ **Payment by credit card:**

Visa, Master Card, American Express, Discover or Care Credit

I have read and understand the Payment Agreement policy of the practice and have chosen my preferred payment method.

I, _____ (print name), have received a copy of the Newton Centre Dental Payment Agreement Policy and have agreed to its terms.

Signature of patient **Date**