

Welcome

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information (Confidential)

Date _____

Name _____ SS# _____ Date of Birth _____

Gender: Male Female Check appropriate box: Minor Single Married Divorced Widowed Separated

If student and over 19 years old, name of school: _____

Address _____

City _____ State _____

Home Phone _____ Work Phone _____ Email _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency? _____

If you could, what would you like to change about your smile: Straighter Teeth Whiter Teeth Other _____

Responsible Party

Name of person responsible for this account _____ Gender: Male Female

Relationship to Patient _____

For your convenience, we accept the following methods of payment. Please check the option you prefer. Payment is due in full for each appointment. Cash Personal Check VISA MasterCard American Express Discover

Insurance Information

Subscriber Name _____ Gender: Male Female

Relationship to Patient _____ Birth date _____ Plan Type: Family Individual

ID Number _____ Group # _____

Subscriber's Employer _____ Work Phone _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Coverage (For Office Use Only)

Updated _____ Coverage used \$ _____ Year _____

I Preventative _____ % \$ _____ deductible Last Prophy ____/____/____

II Basic _____ % \$ _____ deductible Last FMX or Pano ____/____/____

III Major _____ % \$ _____ deductible Last Deep Scaling ____/____/____

Annual Maximum \$ _____ Effective Date of Coverage ____/____/____ Calendar Year Yes No

Missing Tooth Clause Yes No Wait Period Yes No Family Individual

Notes _____

Special Notes Preventative _____

Special Notes Basic _____

Special Notes Major _____

The above is the insurance coverage verified for the above named patient. New England Dental Group as a courtesy will file insurance claims to the insurance company. The insured or patient authorizes the insurance company to pay the provider directly. All deductibles, co-payments, and denied claims will be the total responsibility of the patient. Please feel free to contact any New England Dental Group representative with any questions.

Insured or Patient Signature _____ Date _____

Patient Medical History

Primary Care Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking? _____
4. Have you ever taken Phen-Fen/Redux? Yes No
5. Do you use tobacco? Yes No
6. Do you use controlled substances? Yes No
7. Are you wearing contact lenses? Yes No
8. Do you have or have you had any of the following?

High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pains <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily winded <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen ankles <input type="checkbox"/> Yes <input type="checkbox"/> No	Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever/allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting/seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequently tired <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation therapy <input type="checkbox"/> Yes <input type="checkbox"/> No
Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement or implant <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney diseases <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory problems <input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually transmitted diseases <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach troubles/ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
9. Are you allergic to or have you had any reactions to the following?

Local anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No
..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Any metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Latex rubber <input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No	Other (please list) _____
Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Women Only:
 - a.) Are you pregnant or think you might be pregnant? Yes No
 - b.) Are you nursing? Yes No
 - c.) Are you taking oral contraceptives? Yes No

Patient Dental History

Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck, or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw?
 - a.) Clicking? Yes No
 - b.) Pain (joint, ear, side of face)? Yes No
 - c.) Difficulty in opening or closing? Yes No
 - d.) Difficulty in chewing? Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you ever had any prolonged bleeding following extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
16. Do you like your smile? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I have read and agree with Dr. Jacob Stein Cosmetic and Family Dentistry's (Notice of Privacy Practice) statement.

Signature of Patient (or Parent if Minor) _____ Date _____

Doctor's Comments _____

Signature _____ Date _____