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

Welcome To Beacon Dental Group

PATIENT INFORMATION (CONFIDENTIAL) Today's Date _____

Name_____ Birth Date_____ Soc. Sec. #_____

Home Phone_____ Work Phone _____ Cell _____

E-mail Address _____ Other Contact _____

Address _____ Apt #_____ City _____ State _____ Zip _____

Please Check: Male ___ Female ___ Status: Minor ___ Single ___ Married ___ Divorced ___ Widowed ___

If Minor, Parent/Guardian Name _____ Home phone _____

If patient is a Student, Name of School/College _____

Person to Contact in Case of an Emergency _____ Phone _____

Who is Your Medical Doctor? _____ Phone _____

Who May We Thank for Referring You _____

Patient Medical History Patient Name: _____

Physician _____ Office number _____ Date of last exam_____

.

	Yes	No
1. Are you under medical treatment now?	O	O
2. Have you ever been hospitalized for any surgical operation or serious illness?	O	O
3. Are you taking any medication(s) if yes, what medication(s) are you taking?	O	O

_____

_____

4. Do you use tobacco?	O	O
5. Do you drink alcohol?	O	O
6. Do you use cocaine or other drugs?	O	O
7. Are you wearing contact lenses?	O	O

8. Are you allergic to or have you had any reactions To the following?	Yes	No
Local Anesthetics (e.g. novocaine)……	O	O
Penicillin or other Antibiotics……	O	O
Sulfa Drugs……	O	O
Barbiturates……	O	O
Sedatives……	O	O
Iodine……	O	O
Aspirin……	O	O
Other _____	O	O

9. Women Only:

a) Are you pregnant or think you may be pregnant?	O	O
b) Are you nursing?.....	O	O
c) Are you taking birth control pills?.....	O	O

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

	Yes	No
High Blood Pressure…….	O	O
Heart Disease……	O	O
Chest Pains……...	O	O
Heart Attack…….	O	O
Cardiac Pacemaker……..	O	O
Easily Winded……..	O	O
Rheumatic Fever……..	O	O
Heart Murmur……..	O	O
Stroke……..	O	O
Swollen Ankles……	O	O
Angina…….	O	O
Hay Fever/Allergies……	O	O

	Yes	No
Fainting/Seizures…….	O	O
Frequently tired……	O	O
Tuberculosis…….	O	O
Asthma…….	O	O
Anemia…….	O	O
Radiation Therapy……	O	O
Low Blood Pressure…….	O	O
Emphysema……..	O	O
Glaucoma…….	O	O
Epilepsy/Convulsions…...	O	O
Cancer……O		O
Recent Weight Loss……..	O	O
Leukemia……..	O	O
Arthritis…….	O	O

	Yes	No
Liver Disease……..	O	O
Diabetes……...	O	O
Joint Replacement or Implant…….	O	O
Heart Trouble……..	O	O
Kidney Diseases……..	O	O
Hepatitis/Jaundice……...	O	O
Respiratory Trouble…….O		O
Aids/HIV infection……...	O	O
Sexually Transmitted Disease…….	O	O
Thyroid Problem…….	O	O
Stomach Troubles/Ulcers……	O	O
Other……	O	O

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	O	O
2. Are your teeth sensitive to hot or cold liquids/foods?	O	O
3. Are your teeth sensitive to sweet or sour liquids/foods?	O	O
4. Do you feel pain to any of your teeth?	O	O
5. Do you have any sores or lumps in or near your mouth?	O	O
6. Have you had any head, neck or jaw injuries?	O	O
7. Have you ever experienced any of the following problems in you jaw?		
a) Clicking ……	O	O
b) Pain (joint, ear, side of face)?.....	O	O
c) Difficulty in opening or closing?.....	O	O
d) Difficulty in chewing?.....	O	O

	Yes	No
8. Do you have frequent headache?.....	O	O
9. Do you clinch or grind your teeth?.....	O	O
10. Do you bite you lips or cheeks frequently?.....	O	O
11. Have you ever had any difficult extractions in the past?	O	O
12. Have you had any orthodontic work?.....	O	O
13. Have you ever had any prolonged bleeding following any extraction?.....	O	O
14. Have you ever had instruction on the correct method of brushing your teeth?.....	O	O
15. Have you ever had instruction on the care of your gums?.....	O	O

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 my child or me during the period of such Dental care to third party payers other wise payable to me. I understand that my 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.

_____

Signature of Patient or Parents if patient is a minor.

Date_____

_____

Signature of Provider

Date_____

Beacon Dental Group

1026 Blue Hill Ave, Dorchester MA 02124
Tel. (617) 282-2146 Fax (617) 282-2526

General Informed Consent

We are asking you to read and sign the following. It means you understand the recommended treatment plan or alternative treatment plans that have been presented to you.

I,_____, the patient of record have been informed by the dentist of the need to undergo dental oral medicine treatment as presented to me, and the relevant information regarding my treatment has been read by me and explained to me. I have been fully informed about the diagnosis, details and estimated costs of recommended treatment and alternatives. I agree to accept this recommended treatment as present diagnoses dictate at this time. I understand that as treatment proceeds there may be a need to change the treatment plan. If this occurs, I expect to be informed before any change is instituted.

I have been informed that success of treatment depends upon my cooperation in keeping scheduled appointment, following home care instruction including oral hygiene and dietary instructions, taking prescribe medication, and reporting to my dentist any changes in my health status. I acknowledge that I have not made any warranties or guarantees concerning treatment or its long-term success.

If the patient is under 18 years or incompetent to consent, a parent or legal guardian must sign this general informed consent.

Patient's Name: _____.

Patient's Signature: _____.

Date: _____.

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Financial Policies

- I understand that my insurance company **quoted estimates** to Beacon Dental Group, and is not a guarantee of payment.
- I understand and accept that I am responsible for all payments whether the treatment is covered by insurance or not.
- I understand that my insurance contract is between the insurance company, my employer and me. Any efforts to collect payment from the insurance company will be handled as a **courtesy** by the dental office.
- I understand that it is my responsibility to inform the office of any changes in my dental coverage.
- I am aware that delinquent accounts may be turned over to collections if payment arrangements are not made and I am responsible for any costs incurred.
- I understand my insurance coverage that has been explained to me.
- I understand that **all payments are due on the date of service**. If a payment plan is given during my course of treatment, I agree to pay on time and in full.
- Payments are to be made only in form of cash, checks, and money order, American Express, Visa or MasterCard.
- I acknowledge that appointments are confirmed in advance as **a courtesy** and that failure to show for my appointment without giving adequate **(48 hours)** notice will result in **a $50 charge** to my account and is subject to change. I understand that if confirmation is not done within **24 hours** the company reserves the right to **cancel or reschedule** my appointment. **Initial** _____
- I understand that if I write a check to Beacon Dental Group for payment of treatment or services rendered and the check is returned for insufficient funds, I am still responsible for the payment due (which must be made in the form of cash, money order, or credit card) as well as an additional **$35** check return fee.

I have read, understand and accepted the financial policies as listed above.

_____ _____

Date **Signature of Patient/Guardian**