Elite Dental *of* **Natick**
232 Pond St. 2nd Floor, Natick, MA 01760
Phone: (508) 318-6333 | Fax: (508) 318-6338

HOW DID YOU HEAR ABOUT US?

Patient Name: _____ Date: ___/___/_____

Please put a check mark next to all that apply:

- ☐ Insurance Company: _____
- ☐ Family/ Friend Referral: _____
- ☐ Google Search/ Internet Search
- ☐ Elite Dental of Natick Website
- ☐ Elite Dental of Natick Facebook
- ☐ Other (please specify): _____

What do you like most about your smile?

_____

Are you experiencing any of the following?

- ☐ Cold sensitivity
- ☐ Teeth chipping or wearing
- ☐ Food getting caught between teeth
- ☐ Difficulty flossing
- ☐ Self-consciousness when smiling for photos
- ☐ Biting lips, cheek, or tongue
- ☐ Indentations at the gum line
- ☐ Speech changes or lisping
- ☐ Bad breath
- ☐ Dry mouth or mouth breathing
- ☐ Jaw or muscle pain or headaches
- ☐ Receding gums

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Consent for Treatment

A. I authorize the doctor and his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
B. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
C. I agree to the use of anesthetics and other medication as necessary, and understand these may carry certain risks. I understand I may ask the doctor for a complete listing of possible complications.
D. When undergoing restorative treatment, I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I realize that fillings are rarely "permanent" and usually require periodic replacement. I understand that any time a tooth is prepared, for any reason, there is always irritation to the nerve of the tooth, which may result in post-operative sensitivity or, in some cases, permanent nerve damage requiring root canal treatment or removal of the tooth.

Initials _____

Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance. I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with Elite Dental of Natick.

Initials _____

Records/ X-Rays

Elite Dental of Natick understands that you have the right to request copies of you dental records/x-rays. We can provide your notes and x-rays when you sign our Record Release Form in our office. Because we are licensed by the Massachusetts Board of Radiology to take X-rays, we are required by law to keep all original copies of your dental records.

Initials _____

Right of Access to Family Members / Authorized Individuals

A. When a referral is made to another provider or specialist outside of Elite Dental of Natick, I understand and authorize my health information to be shared to support the other provider to properly diagnose and treat as required.
B. I understand that I have a right to authorize Elite Dental of Natick to disclose and release my protected health information (including diagnoses, x-rays, medical history, prognosis, billing, and treatment plans and history) to authorized individuals. Parents of minors are authorized individuals inherently. Any individual that is 18 years of age or older is required to provide consent to disclose protected health information to specified individuals. To add an authorized person(s) access to such information please indicate below by circling:

My Parents:	Yes	All Records	
My Spouse / Partner:	Yes	All Records	
My Children:	Yes	All Records	
Other (Specify):		All Records	

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Patient Responsibility and Financial Policy Agreement

The goal of Elite Dental of Natick is to provide exceptional customer service and quality dental care with both a professional and compassionate touch. We want to make certain that our financial policies are clear and understood by you. If you have insurance, we will make a good faith estimate of your benefits. We will file the appropriate claim forms with your insurance company. We will also assist you in understanding your dental plan benefits. By signing this form, you understand your responsibility may alter depending on whether a third party (insurance) pays for all, part or none of the charges. Although we will make every effort to help you obtain your benefits, we cannot guarantee payment from your insurance. If the balance on your account is not paid within 90 days of your statement, the account may be closed and the balance may be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges. **All payments are due at the time treatment is rendered**.

I acknowledge my responsibility for payment of services rendered by Elite Dental of Natick in accordance with Elite Dental of Natick fees and terms.

Initials _____

Non-Covered Services Financial Consent

Your insurance company may not provide benefits for all services that are being recommended to you. This does **NOT** mean that you do not require these services. While your insurance makes its best effort to provide services to its plan members based on the plan you are covered under, it may not cover all services that may be necessary for a patient to achieve optimal health. Further, your insurance company is not required or authorized to diagnose treatment – that is the doctor's responsibility.

In situations where your Insurance Company will not cover a service that is mutually agreed upon between the doctor and the patient, the patient will assume financial responsibility for services rendered. The financial policy agreement signed within the new patient paperwork will apply.

Initials _____

Cancellation Policy

We understand life can get in the way and we want to be accommodating to our dental families. We are sympathetic, compassionate, and caring. We do our best to accommodate each patient and their situation, however, our time is reserved for each patient and their specific oral needs and we may charge cancellation fees for excessive cancellations (including late cancels and failed appointments). In order to put us in the best position to provide each patient a high quality care experience, **we require reschedule or cancellation requests to occur with more than 2 business days' notice. We may charge a cancellation fee of $80 for late cancellations or failed appointments, however will accommodate our dental families where possible.** Individuals that have multiple late or failed cancellations may lose their right to reschedule ahead of time and may be added to a short call list for same day openings instead.

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge I am entitled to review the Statement of Privacy Practices at Elite Dental of Natick. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Elite Dental of Natick reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at my request after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Elite Dental of Natick. We may decline treatment if you revoke this consent.

Patient Name: _____ Date ___/___/_____

Patient/Guardian Signature: _____ Date ___/___/_____

Health Insurance Portability and Accountability ACT

The HIPAA Privacy Rule creates national standards to protect individual's medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patient's privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data-for example, to protect public health.
- For patients-it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections
- It empowers individuals to control certain uses and disclosures of their health information.
- Acknowledgement of receipt of Notice of Privacy Practice upon request. You may refuse to sign this acknowledgment.

I, _____, understand my right pertaining to my personal healthcare and insurance information and my right to review the privacy practices at Elite Dental of Natick.

_____ ___/___/_____
Patient/Guardian Signature Date

_____ ___/___/_____
Witness Signature Date

Elite Dental Of Natick

Eaglesoft Medical History

Patient Name: _____ Birth Date: _____ Date Created:

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, c

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:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____