



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



General 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. As such, I authorize the dental practice and doctor to perform any and all forms of treatment, medication, and therapy that may be indicated, including, but not limited to examinations, local anesthetic, restorative treatment, and preventive treatment.
- C. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).
- D. 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.
- E. 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.
- F. I understand that poor eating and oral habits (such as smoking, fingernail biting, alcohol consumption, etc.), poor oral hygiene, and tongue piercings will negatively affect how long my treatment lasts
- G. Certain medications will create "dry mouth." If I have a dry mouth, I may be given recommendations for certain daily treatments to prevent cavities around the restoration(s) as well as my natural teeth.
- H. This general informed consent may remain in effect until treatment is terminated either by the patient, or this dental practice and dental provider, as referenced below, and/or the patient is no longer regarded as a patient of record.
- I. I understand and agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.
- J. I hereby acknowledge that no guarantee, warrantee or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefits in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a dentist cannot predict certainty of success.
- K. I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Initials _____

RADIOGRAPHS

The use of dental radiographs, or x-rays, allows the doctor to detect dental problems early before serious damage is done to your teeth, gums, and supporting bones and structures. If these conditions are not detected until there are visible or painful signs of disease, your oral health can be seriously affected. Dental radiographs are a part of a comprehensive dental oral examination. Your insurance might not cover the x-rays.

PREGNANCY. We do not take x-rays on pregnant women unless absolutely necessary (for example, during an emergency treatment). Please tell us if you are pregnant, might be pregnant, or are trying to become pregnant

Initials _____



General Consent for Treatment Continued

FLUORIDE

Fluoride is effective in preventing and reversing the early signs of tooth decay. Research has shown that there are several ways through which fluoride achieves its decay-preventive effects. It makes the tooth structure stronger, so teeth are more resistant to acid attacks. Fluoride also acts to repair or remineralize areas in which acid attacks have already begun. The remineralization effect of fluoride is important because it reverses the early decay process as well as creates a tooth surface that is more resistant to decay. Coverage for fluoride treatment can vary, depending on your dental insurance plan.

DRUGS AND MEDICATIONS

I understand that I may receive a local anesthetic and/or other medications. In rare instances, patients may have a severe reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing or aspirating foreign objects during treatment. As part of dental treatment, items including, but not limited to, crowns and bridges, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

Nerve injury may occur from the procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste), or loss of some senses, including the sense of smell or vision. Such conditions may resolve over time, but in some cases may be permanent.

Initials_____

RESTORATIONS AND OTHER DENTAL TREATMENT

If I have been informed that restorative treatment of my dental caries is recommended I have also been informed that such treatment includes possible risks, such as but not limited to the following:

- Tooth/teeth may become sensitive to hot and cold liquids or foods
- Root canal treatment may become necessary at any point during or after treatment and may not be avoidable
- Possibility of injury to gums, teeth, and roots adjacent to the tooth being treated, loose teeth
- Possibility of gum recession after the completion of the restoration
- My jaw may be temporarily stiff and/or sore from holding my mouth open during treatment or there may be cracking and/or stretching of the corners of the mouth, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing
- My bite may need to be adjusted after the restoration(s)
- Teeth may become brittle and due to reduced tooth structure may be subject to cracking or fracturing. Unfortunately, hairline cracks are almost always invisible and undetectable, but may be discovered during the treatment process. Crowning or capping the treated tooth/teeth may become necessary. In a worst case scenario, if a fracture occurs or is found, the tooth may need to be extracted
- Pain, swelling, bleeding, infection, bruising, delayed healing, scarring
- Damage to dental appliances
- Retention of tooth structure, bone or foreign material in the body
- Cuts inside the mouth or on the lips
- Allergic and/or adverse reaction to medications and/or materials
- Discomfort, increased spacing between teeth, altered bite, altered speech
- Change in esthetic appearance of teeth and/or smile
- The remaining tooth structure will still be susceptible to recurrent decay as this procedure may not prevent future tooth decay, tooth fracture, infection or gum disease

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 or NO	ALL RECORDS	SPECIFIC INFORMATION	_____
My Spouse / Partner: YES or NO	ALL RECORDS	SPECIFIC INFORMATION	_____
My Children: YES or NO	ALL RECORDS	SPECIFIC INFORMATION	_____
Other (Specify): _____	ALL RECORDS	SPECIFIC INFORMATION	_____

Initials _____





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.**

Further, for procedures that may require multiple appointments (including but not limited to crowns, implant restorations, dentures, orthodontics, and night guards), I understand I will be responsible for the entire procedure when treatment begins.

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. Having a service rendered by the provider constitutes implied consent for treatment.

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.

Initials _____



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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics
Other?	<input type="checkbox"/>	If yes	<input type="text"/>

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

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