Patient Name: _____ Date: _____
Last First

Gender: Male ☐ Female ☐ Family Status: Single ☐ Married ☐ Widow ☐ Child ☐

Birth Date: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Email: _____

Address: _____
Street Apartment#

_____
City State Zip Code

Referral Information:
Whom may we thank for referring you to our practice?

- ☐ Another patient: _____
- ☐ Dental Office
- ☐ Yellow Page
- ☐ Internet
- ☐ Google
- ☐ Our Website
- ☐ Facebook
- ☐ Insurance Company
- ☐ Mall Sign
- ☐ Other

Emergency Contact:

Name: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Dental Insurance Information:

PRIMARY

Subscriber Name: _____ Birth Date: _____

Subscriber ID #: _____ Group #: _____

Employer Name: _____

Insurance Company: _____ Phone: _____

Patient's relationship to insured: Self ☐ Spouse ☐ Dependent ☐ Other ☐

SECONDARY

Subscriber Name: _____ Birth Date: _____

Subscriber ID #: _____ Group #: _____

Employer Name: _____

Insurance Company: _____ Phone: _____

Patient's relationship to insured: Self ☐ Spouse ☐ Dependent ☐ Other ☐

HEALTH HISTORY

Patient Name: _____ Birth Date: _____

Name of Medical Physician: _____ Phone: _____

Date of last dental visit: _____ Reason for today's visit: _____

Please list any medications including herbal supplements you are currently taking: _____

_____

_____

Please list any medication you've had an allergic or other adverse reaction to: _____

Have you ever had any complications following dental treatment? Yes ☐ No ☐

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes ☐ No ☐

If yes, please explain: _____

Are you now under the care of a physician for a particular problem? Yes ☐ No ☐

If yes, please explain: _____

Are you required to Pre-Medicate before dental treatment? Yes ☐ No ☐

Are you taking any medication for the treatment of Osteoporosis? Yes ☐ No ☐

If yes, please list medications: _____

Abnormal blood pressure? If yes, what is it usually? S_____/D_____ Yes ☐ No ☐

Do you consume grapefruit juice, grapefruits or grapefruit extract? Yes ☐ No ☐

Do you take antacids? If yes, how often? _____ Yes ☐ No ☐

Are you taking tagament (climetidine)? Yes ☐ No ☐

Have you ever had any of the following? Please check Yes or No

Yes/No

- ☐ ☐ AIDS/HIV
- ☐ ☐ Alcohol/ Drug Dependency
- ☐ ☐ Anemia
- ☐ ☐ Arthritis
- ☐ ☐ Asthma
- ☐ ☐ Blood Disease
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Cigarette, Pipe, Cigar, or Chewing Tobacco?
  How many per day? _____
- ☐ ☐ Diabetes
- ☐ ☐ Dizziness/Fainting
- ☐ ☐ Epilepsy
- ☐ ☐ Excessive Bleeding
- ☐ ☐ Glaucoma
- ☐ ☐ Growths/Tumors
- ☐ ☐ Hay Fever
- ☐ ☐ Head Injuries
- ☐ ☐ Heart Disease
- ☐ ☐ Herpes
- ☐ ☐ Heart Murmur/MVP/Congenital Heart Defect
- ☐ ☐ Hepatitis/Jaundice
- ☐ ☐ Hiatal Hernia/Acid Reflux
- ☐ ☐ High Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Kidney Disease

Yes/No

- ☐ ☐ Latex Allergy
- ☐ ☐ Liver Disease
- ☐ ☐ Lymph Nodes/Sore/Enlarged
- ☐ ☐ Mental Health Issues
- ☐ ☐ Pacemaker
- ☐ ☐ Previous Biopsies
- ☐ ☐ Osteoporosis
- ☐ ☐ Replacement of Joints
- ☐ ☐ Radiation Treatment
- ☐ ☐ Respiratory Problems
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Rheumatism
- ☐ ☐ Sinus Problems
- ☐ ☐ Skin Disease
- ☐ ☐ Stomach Problems
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease

DRUG ALLERGIES:

- ☐ ☐ Codeine, valium or other sedatives
- ☐ ☐ Penicillin/other antibiotics
- ☐ ☐ Local Anesthetics
- ☐ ☐ Other

Yes/No

WOMEN:

- ☐ ☐ Are you taking Birth Control Medication?
- ☐ ☐ Are you nursing?
- ☐ ☐ Are you pregnant?
  Due Date: _____

DENTAL HISTORY:

- ☐ ☐ Bite/Chew Nails
- ☐ ☐ Biteguard Therapy
- ☐ ☐ Bleeding Gums
- ☐ ☐ Bleaching Treatment
- ☐ ☐ Blisters/Sores on Lips
- ☐ ☐ Burning Sensation on Tongue
- ☐ ☐ Chew on one side of mouth
- ☐ ☐ Clench/Grind Teeth
- ☐ ☐ Gums swollen or tender
- ☐ ☐ Jaw Pain or Tiredness
- ☐ ☐ Loose teeth or broken fillings
- ☐ ☐ Orthodontic Treatment
- ☐ ☐ Pain around ear
- ☐ ☐ Periodontal Treatment
- ☐ ☐ Persistent Bad Breath
- ☐ ☐ Sensitivity to cold, heat, sweets or brushing
- ☐ ☐ Wisdom teeth removed

How often do you floss? _____

How often do you brush? _____

Do you have any health problems that need further clarification? Yes ☐ No ☐

If yes, please explain:

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____

Patient or Guardian Signature Date Doctor Signature Date

FINANCIAL POLICY

We appreciate having the opportunity to serve you and will make every effort to ensure you of quality dental care. We also strive to keep the costs to our patients as affordable as possible. In order to achieve these goals, we need your assistance and understanding of the following payment policy.

Based on the information you provide to us, we estimate your insurance co-payment which is due at the time services are rendered. We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.**

If you have dental insurance, we will be glad to file claims as a courtesy to you. Below is our policy on insurance:

- *It is **YOUR** responsibility to ensure that the insurance information we have on file is complete and accurate. We have no way of knowing when/if your insurance coverage changes.*
- *Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not with your insurance company. The filing of insurance claims is a **courtesy** we extend to our patients. **All charges are YOUR responsibility from the date the services are rendered, whether your insurance company pays or not**. Please remember that not all services are a covered benefit.*
- *Your copayment is due at the time of service. Copayments are estimated from the information your insurance company gives us. We are not responsible for actual payments made by your insurance carrier. After your claim is paid you may owe more money or have a credit that would be refunded to you.*
- *If your insurance company does not pay in full within 45 days, we may require you to pay the balance due.*

In cases of divorced parents, the parent who brings the child to our office will be deemed responsible for payment. Please do not put us in the uncomfortable position between any family disputes.

Any check returned to us by the bank due to insufficient funds will result in a $25.00 service charge to your account.

Sometimes insurance pays less than what we had anticipated. In those instances you are responsible for the balances and will receive a bill. Bills are sent from our office on a monthly basis with a statement mailed to your billing address. Please let us know if your billing address changes. Payment is expected within 7 days.

_____

Patient Signature Date

210 Andover Street, Peabody, MA 01960 Tel 978 532 5550 Fax 978 532 8078

NAVID Family Dental + ASSOCIATES

CANCELLATION POLICY

We pride ourselves in providing a high level of service and quality for our patients. Your appointment is especially held just for you. An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for treatment. We strive to create a schedule that most efficiently provides for the dental needs of all the patients we serve.

Please arrive on-time to your scheduled appointments. Late arrivals cause schedule delays for those patients who arrive promptly for their appointments. Late arrivals will be worked into the schedule if time allows or rescheduled for another day.

We respect each patient's time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could delay us. If we anticipate we will be significantly delayed, every effort will be made to notify you beforehand so you may choose to come later or be rescheduled.

As a courtesy, our office makes an effort to contact our patients to confirm appointments. However, it is the patient's responsibility to keep all scheduled appointments. While we understand that things may come up, we ask for the courtesy of 48 hours' notice if you are unable to keep a scheduled appointment. It is our policy to charge a $25 cancellation fee for any appointment that is broken with less than 48 hours' notice.

Thank you for understanding the value of our services.

Patient name (print): _____

Patient signature: _____ Date: _____

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Electronic Communication

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 978-532-5550.

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient name (print):_____

Patient signature: _____ Date: _____

NAVID Family Dental + ASSOCIATES

GENERAL CONSENT

I the undersigned patient, hereby authorize the undersigned provider to perform procedure(s).

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns that I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the consequences of non-treatment.

I hereby authorize my dentist, and whomever he/she may designate as her assistants, to perform upon me appropriate dental procedures. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he/she deems advisable.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include, but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and re-infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

I have disclosed my health history information, including any allergies, reactions to medicine, diseases and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform procedure(s) and/ or treatment(s). I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I am aware that in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

I confirm that I understand this form and the information contained therein.

Patient name (print): _____

Patient signature: _____ Date: _____

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