PATIENT REGISTRATION

Patient Name_____ How do you prefer to be addressed?_____

Mailing Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Date of Birth_____ ☐ Child ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Home Phone#_____ Work Phone#_____ Cell Phone#_____

E-Mail Address_____ Social Security#_____

Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

If Student, Name of School/College_____ City_____ State_____ ☐ Full ☐ Part

Whom may we thank for referring you to our office?_____

Where would you like us to confirm your appointments? Please check ***one*** of the following: ☐ Home ☐ Work ☐ Cell ☐ E-mail ☐ Text

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of Responsible Party_____ Relationship to Patient_____ Sex: ☐ M ☐ F

Mailing Address_____ City_____ State_____ Zip_____

Age_____ DOB_____ Social Security#_____ ☐ Single ☐ Married ☐ Partnered ☐ Widow ☐ Separated ☐ Divorced

Home Phone#_____ Work Phone#_____ Cell Phone#_____

Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No If *yes*, please continue.

Policy Holders Name_____ Relationship to Patient_____ Sex: ☐ M ☐ F

Mailing Address_____ City_____ State_____ Zip_____

Age_____ DOB_____ SS or Subscriber ID#_____ ☐ Single ☐ Married ☐ Partnered ☐ Widow ☐ Separated ☐ Divorced

Home Phone#_____ Work Phone#_____ Cell Phone#_____

Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group#_____

Insurance Address_____ City_____ State_____ Zip_____

DENTAL HISTORY

****Although dental personnel primarily treat in the area in and around the mouth, your mouth is part of your entire body. Health problems that you have, or medication that you may be taking could, have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions****

Reason for this visit_____

When was your last dental visit?_____ What was done then?_____

How often did you visit the dentist before then?_____

Previous dentists (name & location)_____

Have you had a complete series of dental x-rays taken? □ Yes □ No If yes, when and where?_____

How often do you brush your teeth?_____ How often do you floss your teeth?_____ Is your drinking water fluoridated? □ Yes □ No

	Yes	No		Yes	No
Do you feel pain to any of your teeth	□	□	Are you having discomfort at this time	□	□
Do you bite your lips or cheeks frequently	□	□	Do you feel nervous about having dental treatment	□	□
Have you noticed loosening of your teeth	□	□	Have you ever had a bad experience in a dental office	□	□
Have you had ortho/braces in the past	□	□	Is there anything you dislike about your smile	□	□
Do you have a history of trauma to your jaw	□	□	Is there anything you would like to speak with the Doctor about in private	□	□
Have you ever been diagnosed with TMJ/TMD	□	□	Have you been a patient in the hospital during the past two years	□	□
Do you have any sores, lumps or growths in or near your mouth	□	□	Have you been under the care of a medical doctor during the past two years	□	□
Have you ever had a difficult extraction in the past	□	□	Are you under the care of a physician now	□	□
Have you ever had prolonged bleeding following extractions	□	□	Have you taken any medications or drugs in the past two years	□	□
Do you habitually clench or grind your teeth day or night	□	□	Are you taking any vitamin, herbal supplements or "cures"	□	□
Do you wear a bite plate or other appliance	□	□	Have you ever taken Redux or Pondimin (Fen Phen)	□	□
Do you have a problem with bad breath (Halitosis)	□	□	Have you ever had any excessive bleeding requiring special treatment	□	□
Do you have trouble chewing	□	□	Have you had any head, neck or jaw injuries	□	□
Does food collect between your teeth	□	□	Do you have frequent headaches	□	□
Have you had instructions in oral hygiene	□	□	Are you in good health	□	□
Have you been told you have gum problems	□	□	Have there been any changes in your general health within the past two years	□	□
Have you ever needed to see a periodontist	□	□	Are you wearing contact lenses	□	□

Have you ever experienced any of the following problems with your jaw?

□ Clicking □ Difficulty Chewing □ Difficulty opening or closing □ Pain in or around your ears

Do you currently or have you ever had any problems listed below?

□ Swelling □ Bad Taste □ Bleeding Gums □ Loose Teeth

Are you sensitive to anything listed below?

□ Hot □ Cold □ Biting/Pressure ☐ Sweets □ Other_____

Is there anything related to your medical or dental history that you have not indicated above? ☐ Yes ☐ No If yes, please explain _____

_____

What is your chief dental complaint? _____

_____

MEDICAL HISTORY

Please check any of the following that apply:

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Food:_____
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Metals
- ☐ Other:_____

MEDICATIONS

Please list any medications you are currently taking:

_____

_____

_____

Pharmacy:_____

- ☐ ADD or ADHD
- ☐ Alcoholism/Drug Use
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Any Type of Transplant
- ☐ Arthritis
- ☐ Artificial Joints**
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer (type_____)
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone Treatment
- ☐ Cough That Produces Blood
- ☐ Dental Implant
- ☐ Dentures or Partials
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Genetic Conditions
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Disease or Attack
- ☐ Heart Failure**
- ☐ Heart Murmur
- ☐ Heart Problems**
- ☐ Heart Surgery**
- ☐ Hemophilia
- ☐ Hepatitis A, B, C or Other
- ☐ Herpes
- ☐ High/Low Blood Pressure
- ☐ HIV Positive, ARC or AIDS
- ☐ Hives or Skin Rash
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Medical Implant**
- ☐ Mental Disability
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy
- ☐ Recent Surgery/Hospitalization
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Steroid Treatment
- ☐ Stroke
- ☐ Swelling of Ankles, Feet or Hands
- ☐ Syndromes _____
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Use of Tobacco Products

**Antibiotic pre-medication may be required prior to your appointment if you have any of the following:

1. Prosthetic heart valves 2. A previous bout of infective endocarditis 3. Cardiac transplant recipients who develop valvulitis 4. A congenital heart disease excluding mitral valve prolapse 5. Joint replacements for up to two years

WOMEN

Are you pregnant now? ☐ Yes ☐ No If yes, what is your due date?_____

Are you breast feeding? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. 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.

X_____

Signature of Patient or Guardian **Date**

HD

Hadar Dental, LLC

Payment Policy

Thank you for choosing Hadar Dental, LLC as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service available. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. Please indicate below the method of payment you intend to use.

My preferred payment option is:

___ Cash
___ Check
___ Major credit card (Visa, MasterCard, or American Express)

******* For treatment amounts over $300, please inquire about the possibility of an extended payment plan.

A note for patients with dental insurance

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is delivered to you, your co-payment will be expected at that time. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

Acceptance Agreement

I understand and agree with the above financial policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party _____
Printed Name

_____ _____
Signature Date

Hadar Dental, LLC
3 Bow Street, Lexington, MA 02420
T 781 860 7700 F 781 860 7710
www.hadardental.com

HD

Hadar Dental, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name

_____

Print Patient Name

_____

Signature of Patient or Guardian

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____

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