Family Dentistry
180 Park Street
North Reading, MA.01864
(978)664-2081

Date _____

Patient Information

Patient's Name_____ Date of Birth_____ Male_____ Female____

Patients Soc. Sec. No. ____N/A_____ If minor, parent/guardian Soc. Sec. No.____N/A_____

Single _____ Married _____ Spouse's Name_____

If Child, Parent/Guardian Name_____

Mailing Address _____ Email _____

City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____ Cell # _____

Patient employed by _____

Closest Relative _____ Phone _____

Referred here by_____

Dental Insurance Information

Name of Insured_____ Employed by _____

Insured's Date of Birth _____ Insured's Soc. Sec. No._____

Name of Insurance Co. _____ Group or Policy # _____

Medical History

1. Name of Family Physician _____

In the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

2. Are you in good health?..... Yes No
   Explain _____
3. Has there been any change in your general health within the past year?..... Yes No
   Explain _____
4. My last Physical Examination was on _____ Yes No
5. Are you under the care of a Physician?..... Yes No
   If so , what is the condition being treated?_____
6. Have you been hospitalized or had a serious illness within the past five years?..... Yes No
   Explain_____

(OVER)

7. Do you have or have you had any of the following diseases or problems?

(a) Damaged heart valves or artificial heart valves, including heart murmur..... Yes No

If yes explain_____

(b) Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No

If yes, explain_____

(c) Allergy..... Yes No

(d) Sinus trouble..... Yes No

(e) Asthma..... Yes No

(f) Fainting spells or seizures..... Yes No

(g) Diabetes..... Yes No

(h) Hepatitis, jaundice, or liver disease..... Yes No

(i) Venereal Disease..... Yes No

(j) Epilepsy..... Yes No

(k) Psychiatric problems..... Yes No

(l) Cancer..... Yes No

(m) AIDS or other immunosuppressive disorders..... Yes No

(n) Rheumatic Fever..... Yes No

(o) Hip or joint replacement..... Yes No

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?..... Yes No

9. Have you ever required a blood transfusion?..... Yes No

10. Do you have any blood disorder such as anemia?..... Yes No

11. Are you taking any drug or medicine?..... Yes No

12. Are you taking any of the following:..... Yes No

(a) Antibiotics or sulfa drugs..... Yes No

(b) Anticoagulants (blood thinners)..... Yes No

(c) Medicine for high blood pressure..... Yes No

(d) Cortisone (steroids)..... Yes No

(e) Tranquilizers..... Yes No

(f) Antihistamines..... Yes No

(g) Aspirin..... Yes No

(h) Insulin, tolbutamide (orinase) or similar drug..... Yes No

(i) Digitalis or drugs for heart trouble..... Yes No

(j) Nitroglycerin ..... Yes No

(k) Oral contraceptive or other hormonal therapy..... Yes No

(l) List medications you are presently taking_____

_____

13. Are you allergic or have you reacted adversely to:

(a) Local anesthetics..... Yes No

(b) Penicillin or other antibiotics..... Yes No

(c) Sulfa drugs..... Yes No

(d) Barbituates, sedatives, or sleeping pills..... Yes No

(e) Aspirin..... Yes No

(f) Iodine..... Yes No

(g) Codeine or other narcotics..... Yes No

(h) Other_____ Yes No

14. Chief Dental Complaint_____

I have read and understand the above

Signature of Patient-Parent/Guardian_____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be Provided**

I understand that during my course of treatment that the following care may be provided:

Examinations ✓ Preventative Services ✓ Restorations ✓

Crowns ✓ Bridges_____ Other_____ Patient Initials_____

2. **Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
Patient initials_____

3. **Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials_____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials_____

_____ _____

Patient Signature Date

I, _____ hereby authorize Dr. Singh's office to email me for appointment confirmations.

My is email address:_____

I understand it is my responsibility to notify the office in writing of any change to my personal email address and the office is not responsible for messages sent to an incorrect address that I have supplied or failed to notify the practice in writing of a change to my email address.

I understand that I can opt out of receiving electronic communications by notifying Dr. Martin's office in writing to this effect.

I, _____ hereby authorize Dr. David Martin's office to use **my cell number** to (choose one or both) ____call ____text regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell number is:_____

I also authorize Dr. Martin's office to communicate electronically or by cell phone to me about the following dependents:

Name(Last, first)	Date of Birth
_____	_____
_____	_____
_____	_____

Signature Date of Birth

- North Reading Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____

Patient Name (please print)

_____

Parent or Authorized Representative (if applicable)

_____

Signature Date

For Office Use Only

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

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

_____