Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to Family Dental of Littleton for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Family Dental of Littleton
130 Cottage Street
Littleton NH 03561
(603) 444-2488

I hereby acknowledge receipt of HIPAA privacy regulations.

copies are available upon request

HIPAA Information

Patient Name: _____ Date of Birth: _____

With whom do you authorize us to share your personal dental information?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Preferred contact via : Phone or Text or Email

Preferred contact to confirm appointments: Phone or Text or Email

Preferred phone number that you can be reached at: _____

Email Address: _____

CHOOSE ONLY ONE:

____ DO NOT leave a message

____ Leave a brief message, with a return phone number

____ You MAY leave a detailed message

I understand that it is my responsibility to notify the office of any changes:
Address, phone numbers, email address, including any insurance information, etc. *

Patient Signature: _____ Print: _____ Date: _____

Guardian Signature: _____ Print: _____ Date: _____

OCDG Representative: _____ Date: _____

AAR/2017

Informed Consent for Routine Dental Treatment

In order to provide comfortable dental treatment it is often necessary to administer local anesthesia (Novocaine, Lidocaine, etc.) by injection. This is a commonly performed procedure in dental offices and usually carries very little risk, however, there are risks associated with its use.

Possible complications include but are not limited to:

Local pain and/or infection.

Temporary but potentially permanent numbness or altered sensation to the nerve that goes to the lip, tongue, gum, etc.

Systemic (whole body) reaction including allergic reaction.

Additionally, pain or prolonged discomfort to the jaw joints (TMJ) may occur from treatment. This is a known complication due to wide opening and stress on the jaw joints. Although usually temporary, discomfort and restricted jaw movements for some time might occur.

By my signature I attest that I have read and understand this consent to have local anesthesia administered as necessary and to have routine dental procedures performed. I have provided an accurate history of my medical and dental status including all medications that I am taking.

_____ _____ _____

Patient signature Print name (patient) Date

_____

Witness

_____

Signature of guardian (if minor) / relationship

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Method of Payment

Payment is expected on the day service is provided. We will be glad to submit to your insurance company; however, after 90 days if the balance is unpaid, the unpaid portion becomes the responsibility of the patient.

We accept local (CT) checks, money orders, cash and major credit cards. As of this date, we are unable to accept starter checks or checks over $200.00.

Delinquent accounts transferred to collection will be assessed a fee up to 40% of the unpaid balance.

There is a $25 charge for checks returned unpaid.

Broken Appointments

Missed appointments are a hardship for everyone, including the patient. Our policy requires 24 hour notice to change or cancel an appointment. Your insurance company is not responsible nor will they be billed for missed appointments. Appointments broken without 24 hour notice are subject to a $50.00 charge and may result in termination of treatment.

Duplicate Records

Family Dental of Littleton will be glad to forward your records upon your written authorization that should include the name and address of your current dentist.

Radiographs may be forwarded at no charge to another provider. Patients requesting their own copy will be charged a nominal $25 fee to cover reproduction costs. A minimum of 5 working days is required for this service.

Health Care Information

I give permission to Family Dental of Littleton to share information with my other health care providers.

Patient Signature_____ **Date**_____

Revised 5/5/2016 ds/are