WEST ROXBURY DENTAL ARTS

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Phone: (617)323-0080 Fax: (888)445-7972
www.westroxburydentalarts.com

PATIENT NAME ______________________ **D.O.B.** __________ S/S # __________

INSURANCE NAME__________ ID #__________ **E-MAIL** __________

HOME PHONE __________ **CELL PHONE** __________

ADDRESS __________ **CITY** __________ **ST** ______ **ZIP CODE** ______

WHERE DID YOU HEAR ABOUT US? __________

EMERGENCY CONTACT (*Name and number*) __________

GENERAL HEALTH (CHECK ONE) EXCELLENT___ GOOD ___ FAIR ___ POOR __ **ARE YOU TAKING ANY MEDICATIONS?** NO ___YES___

WHAT MEDICATION AND REASON __________

____

MEDICAL DOCTOR__________ ADDRESS__________ PH: __________

Have you ever been hospitalized OR ANY SURGERY? NO __ YES __ for what and date of last visit:

____

DO YOU NEED TO BE PRE-MEDICATED BEFORE SEEING THE DOCTOR TODAY: YES ________ NO ________

ALLERGIES TO: PENNICILLIN ___ LOCAL ANESTHESIA ___ CODEINE __ LATEX __ ASPIRIN__ NONE__
OTHERS__________

TAKING BIRTH CONTROL PILLS? YES ___ NO___ ARE YOU **PREGNANT?** YES ___ NO___

ARE YOU SUBJECT TO PROLONGED BLEEDING? YES ___ NO ___

HAVE YOU EVER BEEN TREATED FOR (PLEASE CHECK ALL APPLICABLE):

__PAIN IN JAW JOINTS
__ GLAUCOMA
__ DRUG ADDICTION
__ HEART DISEASE
__ HIGH CHOLESTEROL
__ HIGH/ABNORMAL BLOOD PRESSURE
__ DIABETES
__ UBERCULOSIS OR LUNG DESEASE
__ STROKE
__ SEIZURES
__ VENERAL DISEASE
__ HEART MURMUR
__ ARTIFICIAL JOINTS OR ANY METAL IMPLANTS
__ BLOOD TRANSFUSION
__ HEART VALVE
__ CHEMOTHERAPY
__ JAUNDICE
__ EPILEPSY
__ HAY FEVER
__ SINUS
__ ASTHMA/ENPHYSEMA
__ CONGENITAL HEART LESIONS
__ HERPES
__ KIDNEY PROBLEMS
__ AIDS OR HIV VIRUS
__ **OTHER**: __________
__PSHYCHIATRIC TX
__ ANEMIA
__RHEUMATICAL FEVER
__ ULCER
__ ARTHRITIS
__ HEPATITIS A B C
__ LIVER DISEASE
__ HIP REPLACEMENT
__ SMOKER
__ ANGINA PECTORIS
__ ARTIFICIAL HEART VALVE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

*OFFICE POLICY: WE REQUEST THAT ALL OF OUR PATIENTS PLEASE GIVE US 48 HOURS NOTICE TO CANCEL APPOINTMENTS OR WE RESERVE THE RIGHT TO CHARGE $**50.00 FOR ANY BROKEN APPOINTMENTS WITHIN 72HRS AND/OR WITHOUT ANY NOTICE.**

PLEASE NOTE: OFFICE VERIFIES INSURANCE COPAYS AS A COURTESY TO OUR PATIENTS. HOWEVER, ANY ADDITIONAL COPAYS, BALANCES THAT INSURANCE DOES NOT PAY IS THE PATIENT'S SOLE RESPONSIBILITY. PLEASE BE AWARE THAT WHEN YOU ARE QUOTED INSURANCE COPAY, IT IS ONLY AN ESTIMATE; ON ANY MAJOR SERVICES, WE REQUIRE A 50% DEPOSIT IN ORDER TO BOOK AN APPOINTMENT. THANK YOU IN ADVANCE FOR YOUR COOPERATION.

PATIENT/PARENT/GUARDIAN: __________
(PRINT NAME)

PATIENT/PARENT/GUARDIAN: __________
(SIGNATURE)

DENTIST: SRISMITHA MODEM, DMD __________ **DATE**: __________
(PRINT NAME) **(SIGNATURE)**

GENERAL CONSENT FOR TREATMENT

1. **EXAMINATION AND X-RAYS -** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. **DRUGS AND MEDICATIONS -** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

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.

4. **REMOVAL OF TEETH -** Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

5. **CROWNS, BRIDGES AND CAPS -** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

6. **DENTURES - COMPLETE OR PARTIAL -** I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

7. **IMMEDIATE DENTURES -** I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. Understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

8. **PERIODONTAL LOSS (TISSUE & BONE) -** I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. Understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

9. **ENDODONTICTREATMENT (ROOT CANAL) -** I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs and scarring. I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

PATIENT/PARENT/GUARDIAN: ____ **D.O.B.**: ________________

(PRINT NAME)

PATIENT/PARENT/GUARDIAN: ____ **DATE**: ________________

(SIGNATURE)

Office Policies

IMPORTANT – PLEASE READ

WELCOME TO OUR PRACTICE!

Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel comfortable throughout out our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL POLICY

Patients are expected to pay for their services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using **Cash, Check, Visa, MasterCard and/or Discover**. We also offer **CARE CREDIT** and **LENDING CLUB**, which are financing options that are available only for healthcare expenses. Please be advised that in order to use care credit your total co-payment must be at least of $1,000.00, if lesser you have the option to choose a different form of payment. We will mail monthly statements to all patients with an outstanding balance, a charge of 18% per annum after 90 days.

INSURANCE

All of our Doctors will diagnose treatment based on your dental health not your insurance coverage.
As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you receive your maximum allowed benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run from January to December). **Benefits are calculated based on current available benefits and payment eligibility. Estimates are subject to modification based on eligibility, coordination of benefits, the contract allowance, and the benefit plan in effect at the time services are completed. Note: benefits are not coordinated until services are rendered. We can only estimate your copayments, it is your responsibility to know your insurance plan and coverage. Pre-Estimates are not a guarantee of payment.**

You must realize that:

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employee pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit Plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a Dentist may recommend a crown for a tooth that has extensive decay; however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling. **When insurance denies a claim, it is your responsibility to pay for services provided in our office. Any questions, please ask our friendly staff, Thank you.**

APPOINTMENTS (CANCELLATIONS / NO-SHOWS)

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when patients fail to keep their scheduled appointments or cancel at the last minute. **On any major services, we require a 50% deposit in order to book an appointment,** and **at least 48 hours notice for any cancelled appointment. We do have a $50 no show cancellation fee which also applies to any cancellation made less than 48hrs of a scheduled appointment**. After 2 missed appointments or cancelled appointment we will place you on a short call list, which means we will phone you when an appointment becomes available on short notice. This gives you the opportunity to know if our busy schedule has an opening for a dental appointment within the next few hours.

RELEASE OF DENTAL RECORDS

All requests for the release of Dental Records must be submitted in writing and must be dated and signed by the patient or the patient's legally authorized representative. In the case of a minor, the parent or guardian must sign the authorization, and pay a **processing fee of $35.00**. Please allow **72 hours from receipt of this signed release**, for the duplication of records and mailing.

PATIENT/PARENT/GUARDIAN: ____ **D.O.B.**: ________________
(PRINT NAME)

PATIENT/PARENT/GUARDIAN: ____ **DATE**: _________________
(SIGNATURE)

NEW PATIENT SURVEY

When answering, please be as specific as possible. Thank You! ☺

1. **What dental problems cause people the most trouble?**

2. **What would you most want to achieve from dental care?**

3. **How would you describe the perfect dentist?**

4. **What key factors most influence you when choosing a dentist?**

5. **What would be the most convenient days for you to visit the dentist? What would be the most convenient hours?**