



New Patient Information

Back Bay Dental Care
Comfort Is Our First Concern

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ Male Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (____) _____ - _____ Work phone (____) _____ - _____ Cell phone (____) _____ - _____

Primary contact number (please check one) Home Work Cell Best time to call _____

Fax (____) _____ - _____ E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (____) _____ - _____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? Yes No
If so, please describe: _____

Do you have any dental problems now? Yes No
If so, please describe: _____

Have you ever had trouble with a previous dental treatment? Yes No
If so, please describe: _____

Level of anxiety about seeing the dentist: *Circle number* (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (____) _____ - _____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? Hard Medium Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Have you ever had:

- Periodontal disease/gum treatment
Orthodontics treatment
Oral surgery
A bite plate or mouth guard
Discomfort in your jaw joint (TMJ/TMD)
Your teeth ground or bite adjusted
Serious injury to the mouth or head

If you answered yes to any of the previous questions, please describe

Is there anything else about your past dental treatment(s) that you would like us to know?

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years?

If yes, for what?

Hospital or Physician's name Phone

Hospital or Physician's City State

Have you taken any medications or drugs in the past two years?

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines)

If yes, please explain

Have you ever taken Fen-Phen?

If so, how long ago?

Have you been to the doctor to check for heart problems?

If so, what are the problems?

Do you use tobacco? Do you use alcohol or any other controlled substance?

Women only:

Are you pregnant or think you may be pregnant? Are you nursing?

Are you taking birth control pills?

Indicate which of the following you have had or have at present:

- AIDS/HIV, Alcohol/Drug Abuse, Allergies or Hives, Anemia, Arthritis/Rheumatism, Artificial Heart Valve, Artificial Bones/Joints, Asthma, Blood Disease, Blood Transfusion, Bruise Easily, Cancer/Chemotherapy, Chest Pain, Cold Sores/Herpes, Colitis, Contact Lenses, Cortisone Medicine, Diabetes, Diet (Special/Restricted), Difficulty Breathing, Emphysema, Epilepsy or Seizures, Fainting or Dizzy Spells, Frequent Headaches, Glaucoma, Hay Fever, Heart (Surgery, Disease, Attack), Heart Pacemaker, Heart Murmur, Hemophilia/Abnormal Bleeding, Hepatitis A B C (circle), High or Low Blood Pressure, Hospitalized for Any Reason, Jaundice, Kidney Trouble, Liver Disease, Lupus, Mitral Valve Prolapse, Nervousness/Anxiety, Neurological Disorders, Psychiatric/Psychological Care, Radiation Therapy, Rheumatic/Scarlet Fever, Shingles/Chicken Pox, Sickle Cell Disease/Traits, Sinus Trouble, Snoring/Sleep Apnea, Stomach Problems/ Ulcers, Stroke, Swollen Ankles, Thyroid Problems, Tuberculosis (TB), Tumors, Venereal Disease/STD

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- Aspirin, Codeine, Anesthetics (i.e. Novocaine), Erythromycin, Iodine, Jewelry/Metals, Latex, Penicillin or Other Antibiotics, Sedatives, Sulfa Drugs, Tetracycline, Other

Patient signature

Office review



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Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____ Is insured a patient in our practice? Yes No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____ Is insured a patient in our practice? Yes No

Person Financially Responsible for Account

Name _____ Relationship to patient _____
 Social security no. _____ Phone () - _____
 Driver's license no. _____ Date of birth _____
 Address (Street, City, State, ZIP) _____
 Employer _____ Work phone () - _____
 Preferred payment method: Cash Credit Card Check
 Visa/MC/AMEX no. _____ Exp. date _____
 If patient is a minor, name of parent or legal guardian and relationship _____
 Is this parent or legal guardian currently a patient in our office? Yes No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

BBDC Cancellation Policy: Last minute cancellations or no shows have a direct and negative financial impact on the practice as well as its doctors and hygienists. Furthermore, it potentially prevents us from providing much needed care and treatment to another patient. Patients of BBDC are required to provide 48 hours notice if any changes need to be made to their appointment. As such, the practice reserves the right to charge \$50 (per 1/2 hour) for any appointments cancelled without 48 hours advance notice. We appreciate your understanding.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that they release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ Date _____

Person to contact in case of emergency

Name _____ Relationship _____
 City _____ State _____ Cell phone _____
 Home phone _____ Work phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ HYG/DA _____



1. Do you love the way your smile looks? Yes No

2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No

3. If you could change anything about your smile, it would be (check all that apply):

- Color of your teeth Too much or too little of teeth show when you smile Gaps between your teeth
 Size/Shape of your teeth Too much or too little of gum shows when you smile Alignment of your teeth
 Other: _____

4. Do you have (check all that apply):

- Sensitive or receding gums Worn/broken/chipped teeth Old or discolored fillings Missing teeth
 Old crowns that have dark edges at the top Bleeding gums Other: _____

Dental Treatment Consent

1. I authorize dental treatment including or advise local anesthesia, examination, radiographs (x-rays) or diagnostic aids.

2. In general terms, dental treatment may include but is not limited to one or a number of the following of the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planning with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of disease or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
- Stainless steel crowns for children. These are necessary in cases where simple filling would not be the best long term restoration or in cases where there are large cavities.
- The replacement of missing teeth with a dental prosthesis(crown, partials, etc)
- Treatment disease or injured oral tissues (hard/or soft)
- Treatment of malposed (crooked) teeth and/or development abnormalities.
- Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also know as “endodontic” therapy or (root canal treatment)

Risks of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of the a vein), reaction to injections, change in occlusion (biting), muscles cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in the teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or all procedures because of conditions found while working on the teeth that were not discovered during examination. Upon being informed, I will give my permission to the dentist to make any/all changes and addition as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.



Crown (Caps) and Bridges

I understand that sometimes it is not possible to match the color of the 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 in place until the permanent crowns are delivered. I realize the final opportunity to make changes in any new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

Patient/Guardian Signature: _____

Date: _____

Notice of Privacy Practices - Acknowledge of Receipt

The Back Bay Dental Care notice of privacy practices provides information about how we may use and disclosed protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient