

Avalon Dental  
Center

**PATIENT INFORMATION**  
(Confidential)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  Mr.  Mrs.  
 Miss.  Ms.

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone Number(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone Number(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

If Student: School/College Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  F/T  P/T

Emergency Contact \_\_\_\_\_ Phone Number(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How Did You Hear About Our Office? \_\_\_\_\_

*Insurance/Account Information*

Last Name of Insured \_\_\_\_\_ First Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer Sponsoring Insurance Plan \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Insurance Telephone(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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**OFFICE USE ONLY-Effective Insurance Coverage Confirmation**

Date ____/____/____	Deductible: Individual _____ Family _____
Phone Number _____	Annual Maximum _____
Spoke to _____	Ortho Coverage _____
Type I _____	Missing Tooth Clause _____
Type II _____	Waiting Periods _____
Type II I _____	Implants _____
Completed By _____	

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# Patient Medical History

Please answer the following questions completely.

Name of Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Last Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you currently under any medical treatment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking any medications?.....<br>(Including pain relievers, antibiotics, blood thinners, birth control, antidepressants, etc.?)<br>If so, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Women – Are you pregnant or think you may be pregnant?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. When was the last time a doctor listened to your heart and checked your blood pressure? _____<br>Name of doctor _____  |                          |                          |

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- | <i>Do you have/had any of the follows?</i>                                      | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Heart Problems? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| • (Does your physician require pre-medication prior to dental treatment?) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy to Aspirin?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy to Novocaine?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy to Penicillin? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any other Allergies? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what? _____  |                          |                          |
| Diabetes? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis? (Type A__B__C__ ).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement or Implant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (Does your physician require pre-medication prior to dental treatment?) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Stopping Bleeding? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Medical Conditions? _____   |                          |                          |

# Patient Dental History

Previous Dentist \_\_\_\_\_

Dentist Telephone(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Last Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for Changing from Previous Dentist \_\_\_\_\_

What is the purpose of today's visit? \_\_\_\_\_

*Do you have/have you had any of the following?*

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1) Teeth sensitive to heat?.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Teeth sensitive to cold? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Teeth sensitive to sweets?.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Teeth sensitive when biting?.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Pain in any of your teeth? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Swelling in your face or mouth? .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Problems with previous dental treatment? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Bleeding gums?.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Loose teeth?.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Do you like your smile? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health History Update

I verbally reviewed the medical/dental information above with the patient named herein.

Doctor Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctors Comments \_\_\_\_\_

1. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Changes: Yes/No

Comments: \_\_\_\_\_ Initials \_\_\_\_\_

2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Changes: Yes/No

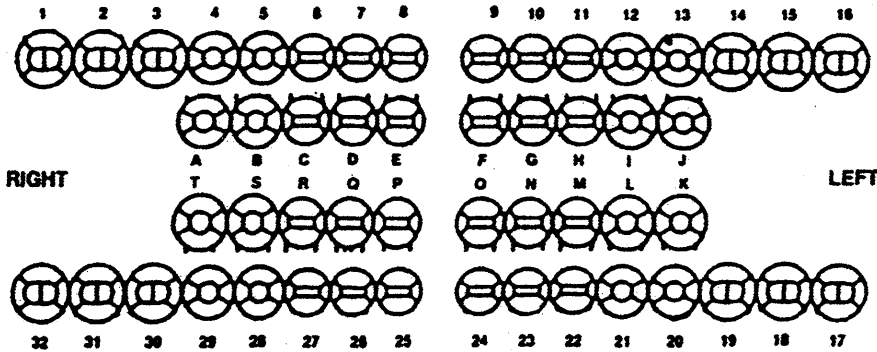
Comments: \_\_\_\_\_ Initials \_\_\_\_\_

3. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Changes: Yes/No

Comments: \_\_\_\_\_ Initials \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ EXAM DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Head & Neck	TMJ	Oral Cancer Exam	Consult Recommended	___ Yes ___ No
Periodontics	Oral Hygiene	Case Type I II III IV	Consult Recommended	___ Yes ___ No
Orthodontics	Occlusion Type		Consult Recommended	___ Yes ___ No
Oral Surgery	Extraction #		Consult Recommended	___ Yes ___ No
Implants	Consult Recommended	___ Yes ___ No		



Arch Rehabilitation  
Maxillary Options

Mandibular Options

	CLINICAL SIGNS & SYMPTOMS		TREATMENT OPTIONS
TOOTH		TOOTH	
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	
7		7	
8		8	
9		9	
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30		30	
31		31	
32		32	

**CONSENT FOR TREATMENT**

Dr. \_\_\_\_\_ has explained the nature of my condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches. Just as there may be benefits to the procedure proposed, I understand that all procedures involve risks to some degree. These general risks may occur in connection with the procedure(s) proposed for me: infection, bleeding, numbness, recurrence, or need for further treatment such as root canal therapy, or extraction. I am aware that other unexpected risks or complication may occur and that no guarantees or promises have been made to me concerning the results of any procedure or treatment. It has also been explained that during the course of the proposed procedures, unforeseen conditions may be revealed requiring the performance of additional procedures. I have read this form and have discussed it with my dentist, and I understand it. I request the performance of the procedure(s) described.

\_\_\_\_\_  
Patient Signature Date

I have explained the above statements to the patient and answered all questions.

\_\_\_\_\_  
Doctors Signature Date

# TREATMENT ALTERNATIVES

Plans and costs are estimates only. Dental treatment frequently changes in mid-course. Additional Root Canal Therapy may be indicated if symptoms develop after treatment of decayed teeth. Insurance benefits will be coordinated to get you your maximum allowable benefit.

## IDEAL TREATMENT

## COSMETIC OPTIONS

## GOOD DENTISTRY

## MINIMAL MAINTENANCE

Please read each section and sign below.

### PAYMENT IS DUE IN FULL UPON SERVICES RENDERED

If you have insurance coverage, our staff will calculate estimated insurance payments for services rendered. We cannot, however, be responsible for actual payment made by your insurance carrier. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

### AUTHORIZATION AND RELEASE

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or health practitioners.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature of Patient/Parent/Guardian

Date

### ~~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)

# Avalon Dental Center

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120 Temple Street

Somerville, MA 02145

160 Cambridge Street

Cambridge, MA 02141

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is the statement of our Financial Agreement, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service. We accept cash, visa, master card, and Discover. Should you request, we will be glad to provide you with office payment plan options. We will be glad to bill to your insurance carrier, however all estimated co-payment amount. Please be advised that any balance left unpaid by your insurance carrier, will be your responsibility.

Here at Avalon Dental Center, we use Composite **(Resin) material only. Please refer to your insurance policy in regards to the contract limitations with posterior multi-surface fillings.** In the event your policy does not provide coverage for these procedures or at a lesser rate of coverage, then again any unpaid balance will be your responsibility. We will be glad to answer any questions you have in regards to this issue.

Being that this is a family oriented practice, we ask that all minors are accompanied by his or her parent or legal guardian. Unaccompanied minors will be denied emergent treatment unless prior consent and financial arrangements have been made.

## Appointment Policy

We do require at least 24 hour notice when canceling an appointment. Should an appointment be cancelled or missed with insufficient notice there will be a \$50.00 failed appointment be applied to your account and must be settled before additional treatment is rendered. After 3 No-shows we hold the right to dismiss you from our office.

In the days prior to your appointment you may receive a confirmation call which must be returned to confirm that you will indeed be attending your appointment. This is set in place so that we may better serve our patients and their schedules.

I understand there will be a duplication fee of \$15 per chart and this fee must be paid in full along with any balance on my account.

## **We require positive identification at the time of the appointment.**

Please let us know if you have any questions regarding this policy.

By signing below you agree to our office Policies and Procedures.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Social Security: \_\_\_\_\_

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## SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of our protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Consent:** By signing this form, you will consent to our use and disclosure of our protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right of our Notice of Privacy Practice before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read carefully and completely before signing this Consent.

We reserve the right to change our practices as described in our notice of privacy Practices.

If we change our privacy practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of you protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revision of our Notice, at any time by contacting our office Avalon Dental Center at 617-374-9500, or fax: 617-374-9501.

**Right to Revoke:** You will have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**