Chart #
FOR OFFICE USE ONLY

TUFTS DENTAL Associates

A Full Range of Care Provided by Faculty

One Kneeland Street, 8th Floor • Boston, MA 02111 • Phone 617-636-6678 • Fax 617-636-3585

PATIENT INFORMATION

Patient Name: _____ Date: _____
LAST FIRST MI (PREFERRED NAME)

Birth Date: _____ Gender: _____ Family Status: _____

Address: _____
STREET APARTMENT # E-MAIL

_____
CITY STATE ZIP CODE

Phone (Home): _____ (Work): _____ Ext. _____ Cell (Other): _____

Emergency Contact: _____
NAME RELATIONSHIP PHONE NUMBER

RESPONSIBLE PARTY INFORMATION

Name: _____ Birth Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Phone (Home): _____ (Work): _____ (Cell) _____ Best time to call: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
STREET CITY STATE ZIP CODE PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Name of Insured: _____
LAST FIRST MI

Insured's Birth Date: _____ ID #: _____ Group#: _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Insured's Employer Name: _____

Address: _____
STREET CITY STATE ZIP CODE

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name & Address: _____

SECONDARY INSURANCE CARRIER

Name of Insured: _____
LAST FIRST MI

Insured's Birth Date: _____ ID #: _____ Group#: _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Insured's Employer Name: _____

Address: _____
STREET CITY STATE ZIP CODE

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name & Address: _____

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PATIENT UNDERSTANDING AND INFORMED CONSENT

Health Care Operations: Tufts Dental Associates may use and disclose your health information in connection with our healthcare operations. See *Notice of Privacy Practices* provided for your signature for a complete description.

Consent to Dental Procedures: Prior to receiving dental care, you are encouraged to ask any questions that you might have before you give your consent for dental treatment. All dental procedures may involve risks or unsuccessful results and complications, and no guarantees are made regarding any result or cure. You, as our patient, have the right to be informed of any such risks and potential consequences of not performing treatment, the nature of the procedure, expected benefits, and availability of alternative methods of treatment. You have a right to consent to or refuse any proposed procedure at any time prior to its performance. Tufts Dental Associates also reserves the right to not perform specific treatment requested by a patient.

X-Rays: Dental x-rays will be taken as necessary and appropriate for examinations, diagnoses, consultations, and treatments.

Photographs: Patient photographs may be taken to document a clinical condition and record examination findings.

Patient's Financial Responsibility: Payment for services is due at the time of the appointment. An estimate of fees and consultation will be provided prior to treatment. As a courtesy, Tufts Dental Associates can submit claims to insurance companies on the patient's behalf for direct reimbursement to the patient. Patients may also be asked to provide personal identification that may include a picture I.D. and social security number to process dental insurance claims.

Dental Records: The dental records, x-rays, photographs, models, and other diagnostic aids that relate to your treatment are the property of Tufts Dental Associates. You have a right to make an appointment to inspect these materials and/or request a copy of them. Tufts Dental Associates may charge a reasonable administrative fee for this service. You may also request to have a copy of your dental x-rays sent to another health care provider by completing a written request.

Keeping Your Appointments: Since a time is reserved for you as a valued patient, we request that you be on time for your appointments and in return Tufts Dental Associates will strive to be on time for your appointment. If you find that you are unable to keep an appointment, Tufts Dental Associates asks that you please notify the office at least 24 hours in advance. A total of three cancellations without 24 hour notice, three missed appointments, or repeated unsuccessful attempts to arrange an appointment may be cause to discontinue your dental treatment.

Emergency and After-Hours Care: Emergency dental care is generally temporary treatment that is intended to provide relief of severe pain and infection for one tooth or area. It is the patient's responsibility to make arrangements for follow-up care that may be required to alleviate or resolve the dental problem. For after-hours care, please phone the office and follow the recorded instructions.

The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, *the parent or guardian of the patient with authority to give consent,* or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____

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Medical History Questionnaire

Tufts Dental Associates

Patient Name: _____ Date: _____

Reason for appointment: _____

Who referred you to our office: _____

Please answer all questions by checking the YES or NO box. Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
❑	❑	High blood pressure
❑	❑	Heart disease from childhood
❑	❑	Heart murmur
❑	❑	Rheumatic fever
❑	❑	Use of Phen-Fen
❑	❑	Pacemaker
❑	❑	Vascular graft
❑	❑	Heart valve replacement
❑	❑	Heart attack
❑	❑	Heart surgery
❑	❑	Congestive heart failure
❑	❑	Angina (chest pain)
❑	❑	Irregular heart beat
❑	❑	Stroke
❑	❑	Increased cholesterol

Endocrine/Hematologic/Oncologic/Immune:

YES	NO	
☐	☐	Frequent hunger
☐	☐	Frequent thirst
☐	☐	Diabetes
☐	☐	Thyroid disease
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Bleeding tendency
☐	☐	Anemia
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	HIV infection/AIDS
☐	☐	Organ transplant
☐	☐	Blood transfusion

Do you have, or did you ever have, any of the following?

Musculo-Skeletal/CNS/Developmental

YES	NO	
☐	☐	Chronic jaw and facial pain?
☐	☐	Chronic headache pain?
☐	☐	Chronic neck pain?
☐	☐	Popping or clicking in your jaw?
☐	☐	Joint replacement
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Spinal cord injury
☐	☐	Seizures
☐	☐	Dizziness
☐	☐	Weakness
☐	☐	Multiple Sclerosis
☐	☐	Cerebral palsy
☐	☐	Mental retardation
☐	☐	Dementia / Alzheimer's
☐	☐	Fainting spells
☐	☐	Visual impairment
☐	☐	Glaucoma
☐	☐	Hearing impairment

GI/GU:

YES	NO	
☐	☐	Hepatitis (A, B, C, or other?)
☐	☐	Kidney dialysis
☐	☐	Ulcers
☐	☐	Sexually transmitted disease
☐	☐	Denied permission to give blood
☐	☐	Gastroesophagal disease (Gerd)

Psychological:

YES	NO	
☐	☐	Anxiety/Nervousness
☐	☐	Depression
☐	☐	Mental health treatment
☐	☐	Insomnia

Over Please

Do you have, or have you ever had, any of the following?

Respiratory:

YES	NO	
☐	☐	Asthma
☐	☐	Chronic Sinus Problems
☐	☐	Night sweats
☐	☐	Emphysema
☐	☐	Tuberculosis

Other: _____

Social:

YES	NO	
☐	☐	Do you use tobacco products?
		If so, how much?_____
☐	☐	Do you drink alcohol?
☐	☐	Every day?
		If so, how much?_____
☐	☐	Do you use recreational drugs?

Medication Allergy or Intolerance:

YES	NO	
☐	☐	Penicillin
☐	☐	Dental anesthetic ("Novocain")
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Latex products
☐	☐	Iodine
☐	☐	Sulfa Drugs

Other: _____

_____

Do you have any medical condition(s) not already mentioned?

_____

_____

History of Hospitalization/Surgical Procedures:

_____

_____

Family: Has a parent, sibling, or child of yours ever had any of the following?

YES	NO	
☐	☐	Diabetes
☐	☐	High blood pressure
☐	☐	Heart disease
☐	☐	Bleeding tendency
☐	☐	Cancer

Medications:

YES	NO	
☐	☐	Are you taking any prescription medicines, any over-the-counter items, or any herbal medicines now?

If so, please list them and the doses you use:

_____

_____

_____

_____

_____

_____

_____

_____

Other:

YES	NO	
☐	☐	Does the amount of saliva in your mouth seem to be too little?
☐	☐	Does your mouth feel dry when eating a meal?

FEMALES ONLY:

YES	NO	
☐	☐	Are you pregnant now?
		If so, #____ months
☐	☐	Do you take birth control pills?
☐	☐	Are you breast feeding now?

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medications, I will inform my Tufts Dental Associates Practice dental health care provider at my next appointment.

_____ _____

Signature of patient (or Parent of Guardian if patient is under 18) **Date**

_____ _____

Doctor Signature **Date**

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Dental Insurance Coverage Notice and Disclaimer

1. I understand and agree that Tufts Dental Associates does not represent my dental insurance company and that Tufts Dental Associates cannot make any representation or warranty that my dental insurance company will cover any or all portions of the dental services rendered.

2. I further understand that I will be billed and will be responsible to pay for any and all amounts not paid or covered by my dental insurer.

3. I realize that bills will include amounts incurred from deductibles, co-payments and amounts not paid by my dental insurer due to the maximizing of my benefits.

4. I acknowledge that it is my ultimate and sole responsibility to determine whether a dental service, procedure or treatment program is covered by my dental insurer and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure and/or program.

5. I acknowledge and understand that Tufts Dental Associates will not, as a matter of policy, agree to halt any service, procedure and/or treatment solely because my dental insurance benefits have been maximized and that Tufts Dental Associates can not know at what point in my dental care that my insurance has been maximized.

6. I confirm that no representation has been made to me by Tufts Dental Associates that is contrary in any way to the aforementioned notice and disclaimer and that any statement made by Tufts Dental Associates concerning my dental insurance benefits cannot be relied upon as a guaranty of coverage.

7. I acknowledge that it is my ultimate and sole responsibility to confirm dental insurer participation which is dependant upon the dentist rendering treatment not upon Tufts Dental Associates.

SIGNATURE OF PATIENT/GUARDIAN

DATE

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FINANCIAL POLICY

Thank you for choosing our practice to meet your dental needs. Our goal is to create a relaxed environment where we provide comprehensive dental care by leading edge practitioners who not only practice dentistry, but also teach and are involved in research to improve oral health.

NON-INSURED PATIENTS:

Payment in full is required at the time of service. However, we will make payment arrangements for major procedures. These arrangements must be made **before** treatment is started.

INSURED PATIENTS:

We accept dental plans that do not assign you to a particular dentist, currently with the exception of Atlus Dental, Fortis (Assurant), Blue Cross/Blue Shield, Dental Blue, and Delta Dental. It is your responsibility to know your benefits and coverage, including yearly maximums, waiting periods, and any other coverage exceptions or limitations.

However, we will contact your insurance carrier to verify your benefits and determine your estimated coverage. This is usually a rough estimate because the insurance company does not have to reveal the maximum fee it will reimburse for services, generally referred to as the UCR or the usual and customary rate/fee. As a courtesy, we will file your claim and require that the benefits be assigned directly to our office. We expect you to pay the uncovered portion of your services the day your services are rendered. If your insurance carrier has not paid their portion within 60 days you are immediately responsible for the balance in full. **YOU ARE RESPONSIBLE FOR ANY AMOUNT THAT YOUR INSURANCE DOES NOT PAY.**

ALL PATIENTS:

Our fees are subject to change. Any outstanding balance not paid at the time services are rendered, will be turned over to our collection agency after 60 days. The patient or person responsible for the account agrees to pay any administrative fees, attorney fees, court costs, or any other costs of collection. Accounts sent to our collection agency are subject to a 15% Collection and/or Attorney Fee. Effective January 1, 2008, any accounts having a balance over 45 days past due will be assessed an interest of 12% APR.

CANCELLATION AND RESCHEDULING POLICY:

Please be advised that we require 24-hour notice be given to reschedule or cancel appointments. If 24-hour notice is not given, you may be subject to a $50 per appointed hour charge. We confirm appointments within two days to one week of your appointment, depending on your dental service type. We request a call back for confirmation of scheduled appointments.

I HAVE READ THIS FINANCIAL POLICY AND ACCEPT THE CONTENT.

Please Print Name: _____

_____ _____

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

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Acknowledgement of Receipt of Notice of Privacy Practices

I,_____, have received a copy of Tufts University *Notice of Privacy Practices*.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

❍ Individual refused to sign,

❍ Communication barriers prohibited obtaining the acknowledgement,

❍ An emergency situation prevented us from obtaining acknowledgement, or

❍ Other (Please Specify)

_____

Information recorded by: _____ Date: _____

You May Refuse to Sign This Acknowledgement