DENTAL ASSOCIATES *of Arlington*

Welcome! Please take a few moments to complete the information below so that we can get to know you better and provide you with the very best dental care. We look forward to serving your dental needs! Thank you!

Patient Name: ____
Last First MI Preferred Name

Title: ________ Gender: ___________ Family Status: ○Married ○Single ○Child ○Other

Birthdate: _________________________________ SS#___________________________________

Email Address: _____________________________ Best time to Call: _________________________

Phone: ______________________ _____________________________ ___________________________
Home Work Ext Mobile

Address: ____

____ __________________ ______________
City State Zip Code

How would you prefer to be contacted? Would you like to be contacted by email for reminders?

____

Do you have any family members who are patients in our office? How are they related?

____

How did you hear about our office?

____

22 Mill Street, Suite 104
Arlington MA 02476
781-648-0279

Dental Insurance

If you have dental insurance, please provide us with the following information:

Name of Subscriber: ____
Last First MI

Patient's relationship to subscriber: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____

Subscriber's date of birth: __________________ Insurance ID# or SSN: __________________________

Subscriber's Employer: ____ Phone: ________________

Address: ____

____
City State Zip Code

Secondary Dental Insurance

If you have secondary dental insurance, please provide us with the following information:

Name of Subscriber: ____
Last First MI

Patient's relationship to subscriber: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____

Subscriber's date of birth: __________________ Insurance ID# or SSN: __________________________

Subscriber's Employer: ____ Phone: ________________

Address: ____

____
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Medical History

Please “check” all of the medical conditions that apply to you below.

- ○ AIDS/HIV
- ○ Allergy- Aspirin
- ○ Allergy- Hay Fever
- ○ Allergy- Other
- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Bisphosphonate Medications
- ○ Bleeding Disorders
- ○ Blood Disease
- ○ Blood Thinner Medications
- ○ Blood Pressure Meds
- ○ Cancer
- ○ Codeine Allergy
- ○ Diabetes
- ○ Dilantin Medications
- ○ Dizzy/Fainting
- ○ Dry Mouth (Xerostomia)
- ○ Epilepsy/Seizure disorders
- ○ Glaucoma
- ○ Headaches/Migraines
- ○ Heart Disease
- ○ Heart Murmur
- ○ Heart Valve Replacement
- ○ Hepatitis
- ○ High Blood pressure
- ○ High Cholesterol
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Immunosuppressed
- ○ Joint Replacement (see below)
- ○ Kidney Disease
- ○ Latex Allergy
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Mental Disorders
- ○ Metal Allergy
- ○ Mitral Valve Prolapse
- ○ Nervous Disorders
- ○ No Epinephrine
- ○ Osteoporosis
- ○ Other (See Below)
- ○ Pacemaker
- ○ Penicillin Allergy
- ○ Pregnancy
- ○ Pre-Medication
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Sinus Problems
- ○ Sleep Apnea
- ○ Smoker
- ○ STD’s
- ○ Stomach Problems
- ○ Stroke
- ○ Tuberculosis
- ○ Tumors
- ○ Ulcers
- ○ Venereal Disease

If you indicated “Other” above, please explain: ____

____

If you indicated you had a joint replacement(s), please include which joint(s) and the date(s) of replacement(s):____

____

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Medical History, Continued

Current Medications: ____

ALLERGY to the following medications: ____

____

Have you been hospitalized within the past 5 years due to surgery or illness? If yes, please explain: ____

____

____

Primary Care Physician: ____
Name Telephone Number

Preferred Pharmacy: ____

Emergency Contact: ____
Name Relationship Telephone Number

Dental History

If you could change anything about your mouth, teeth, or smile what would it be? __________________

____

____

What is the reason for your dental visit today? ____

When was your last visit to a dentist, and/or last dental cleaning? _______________________________

Here at Dental Associates of Arlington we offer Conscious Sedation for those patients who have a fear of going to the dentist. Are you interested in "Sedation Dentistry"? ○ YES ○ NO

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DENTAL ASSOCIATES of Arlington

Please read the following information regarding our Office Policies and Consent for Treatment. Please check of each item to indicate you have read and understand.

Consent for Treatment

○ I give permission to Dental Associates of Arlington to perform a Comprehensive examination necessary to accurately diagnose my treatment needs. I certify that my health history information is accurate to the best of my knowledge and it is my responsibility to inform the office of any changes to my health.

Appointment Policy

○ Here at Dental Associates of Arlington we make appointments that work best with your schedule as well as ours. We understand that situations may arise after having scheduled an appointment, however we require two business days notice to cancel or reschedule an appointment. Appointments cancelled or rescheduled with less than two business days are subject to a cancellation fee. Thank you for your consideration.

Privacy Policy

○ We are required by federal and state law to maintain the privacy of your information and to offer you a copy of our privacy practices. You may request a copy of this Notice of Privacy Practices at any time.

○ We will not release any copies of your records without written consent from you. Duplicate records may be requested by you at any time. Duplicate records are subject to a processing fee.

Financial Policy

It is our goal for our patients to understand their treatment needs, as well as their financial responsibility before treatment begins.

○ We welcome cash, check, debit cards and major credit cards

○ We are pleased to offer outside financing through Care Credit

○ All co-payments are due at the time of scheduling

○ As a professional courtesy for our patients with dental insurance benefits, we will submit your claim to your dental insurance company. Please understand that this is ONLY AND ESTIMATE AND NOT A GUARANTEE OF PAYMENT. Any portion not covered by your insurance plan is the RESPONSIBILITY OF THE PATIENT.

Signature:____ Date: _____________

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