BACK BAY
FAMILY DENTISTRY

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Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: Single, Married, Widowed or Student: _____ _____

Social Security #: _____ Drivers License: _____ State:_____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code
Email Address: _____

Emergency Contact person: _____Relationship:_____ Phone #:_____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer_____
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valves
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous/Anxious
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Bruise Easily
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Sensitivity
- ☐ Cold Sores/Fever Blisters
- ☐ Psychiatric/ Psychological Care
- ☐ Neurological Disorder
- ☐ Thyroid Disease

List Allergies:

- ☐ Other:_____
- ☐ Other: _____
- ☐ **TOBACCO USE**

_____

Women: Are you: **Pregnant?** Yes, ____ months No **Nursing?** Yes No **Taking birth control pills?** Yes No

- List current medications: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Previous Dentist Name: _____Address: _____
- Date of Last Dental Visit: _____Last Dental Cleaning: _____ Last Full Mouth X-rays: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

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

Social Security #: _____ Driver's License #: _____ Issuing State: ____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____ how long have you worked there? _____

Address: _____
Street City, State Zip Code Phone

Dental Benefits Information

Primary

Insurance Company Name: _____ Insurance Phone #: _____
Insurance Company Claims Address: _____
Insured Name: _____ Relationship to Patient: _____
ID/Policy Number: _____ Cardholders's SSN: _____ Birth Date: _____

Secondary

Insurance Company Name: _____ Insurance Phone #: _____
Insurance Company Claims Address: _____
Insured Name: _____ Relationship to Patient: _____
ID/Policy Number: _____ Cardholders's SSN: _____ Birth Date: _____

Consent for Services

I hereby authorize the doctors or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctors to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize the doctors to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 1-3/4% finance charge (21% APR) may be added to my account. I understand that if my account is not paid, I would be turned over to a collection agency and /or attorney and I would be responsible for any collection fees (40% of unpaid balance), interest at the legal rate and responsible attorney fees. I hereby authorize Back Bay Family Dentistry, along with any billing services, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home or work phone using live calls, automatic telephone dialing systems and/or other computer assisted technology.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible part