WELCOME

CROWN DENTAL GROUP

500 Congress Street, Suite 3E, Quincy, MA 02169

Telephone: (617)328-0693 Fax: (617)328-0694

PATIENT INFO

Date:____/____/____

Patient Name:_____

LAST FIRST MI

Prefer To Be Called:_____ ☐ Single ☐ Married

Date of Birth:____/____/____ Age:_____

SS#:_____ ☐ Male ☐ Female

Mailing Address:_____

_____

CITY STATE ZIP

Home Phone #:_____

Work Phone #:_____ Ext:____

Cell Phone #:_____

Best Time to Call:_____

E-mail Address:_____

Emergency Contact:_____

Name Phone #

Employer:_____

Employer's Address:_____

_____

CITY STATE ZIP

Occupation:_____

INSURANCE INFO

Primary Dental Insurance

Co. Name:_____

Address:_____

_____

CITY STATE ZIP

Phone #:_____ Group #:_____

Insured's ID#:_____

Insured's Name:_____

Relation:_____ Date of Birth:_____

Insured's Employer:_____

Secondary Dental Insurance

Co. Name:_____

Address:_____

_____

CITY STATE ZIP

Phone #:_____ Group #:_____

Insured's ID#:_____

Insured's Name:_____

Relation:_____ Date of Birth:_____

Insured's Employer:_____

OFFICE USE ONLY-*Effective Insurance Coverage Confirmation*

Date:____/____/____

Phone #:_____

Spoke to_____

Type I_____

Type II_____

Type III_____

Deductible: Individual_____ Family_____

Annual Maximum_____

Ortho Coverage_____

Missing Tooth Clause_____

Waiting Periods_____

Implants_____

Note:_____

Completed By_____

NAME: _____ **DATE:** _____

Medical Doctor: _____ **Tel. # of Medical Doctor:** _____

DENTAL INFO

Reason for today's visit: ☐ Exam ☐ Emergency Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth ☐ Teeth grinding

☐ Red, swollen or bleeding gums. ☐ Locking Jaw ☐ Ringing in Ears ☐ Bad Breath

☐ Blisters/Sores n or around the mouth. ☐ Broken/Chipped tooth ☐ Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Last Dental exam: ____/____/____ Times a week you floss? _____

MEDICAL INFO

Are you taking any of the following medications? ☐ **Nerve pills** ☐ **Pain killers (including aspirin)**

☐ **Muscle relaxers** ☐ **Stimulants** ☐ **Blood Thinners** ☐ **Tranquilizers** ☐ **Insulin**

☐ **Other(s), please list:** _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

☐ Y N ☐ Heart Attack/Stroke	☐ Y N ☐ Thyroid Problems	☐ Y N ☐ Cancer/Tumors
☐ Y N ☐ Heart Surg./Pacemaker	☐ Y N ☐ Kidney Problems	☐ Y N ☐ Shingles
☐ Y N ☐ Heart Murmur	☐ Y N ☐ Liver Problems	☐ Y N ☐ Hepatitis
☐ Y N ☐ Rheumatic Fever	☐ Y N ☐ Respiratory Problems	☐ Y N ☐ HIV+/AIDS/ARC
☐ Y N ☐ Mitral Valve Prolapse	☐ Y N ☐ Sinus Problems	☐ Y N ☐ Arthritis/Rheumatism
☐ Y N ☐ Artificial Valves	☐ Y N ☐ Stomach Problems/Ulcers	☐ Y N ☐ Artificial Bones/Joints
☐ Y N ☐ Heart Disease	☐ Y N ☐ Psychiatric Problems	☐ Y N ☐ Emphysema
☐ Y N ☐ Congenital Heart Defect	☐ Y N ☐ Venereal Disease	☐ Y N ☐ Fainting/Seizures/Epilepsy
☐ Y N ☐ Chest Pains	☐ Y N ☐ Alcohol/Drug Abuse	☐ Y N ☐ Severe/Frequent Headaches
☐ Y N ☐ Scarlet Fever	☐ Y N ☐ Tuberculosis TB	☐ Y N ☐ Frequent Neck Pain
☐ Y N ☐ Nervousness	☐ Y N ☐ Jaw Problems TMJ.TMD	☐ Y N ☐ Back Problems
☐ Y N ☐ Cosmetic Surgery	☐ Y N ☐ Asthma	☐ Y N ☐ Anemia
☐ Y N ☐ Radiation Therapy	☐ Y N ☐ Difficulty Breathing	☐ Y N ☐ High/Low Blood Pressure
☐ Y N ☐ Chemotherapy	☐ Y N ☐ Diabetes/Hypoglycemia	☐ Y N ☐ Bleeding Problems
☐ Y N ☐ High Cholesterol	☐ Y N ☐ Glaucoma	

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin

☐ Dental Anesthetics ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How Long? _____

Do you wear contact lenses? ☐ Yes ☐ No Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No

For women: Are you taking Birth Control pill? ☐ Yes ☐ No Are you pregnant? ☐ No ☐ Yes/How long? ____

Reviewed by Dr. _____

☺ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provide.

Signature _____ **Date** ____/____/____

Adult Patient Parent or Guardian Spouse

Reviewed By Dr. _____ **Date:** ____/____/____

CROWN DENTAL GROUP

Dedicated to Improve and Personalize Oral Health Care

Appointments Available

Monday: 9am-2pm
Tuesday: CLOSED
Wednesday: 9am-6pm
Thursday: 8am-6pm
Friday: 9am-4pm
Saturday: By Appointment

Please call (617) 328-0693 for an appointment.
In order to better serve you, our office will be closed occasionally so our doctors and staff may attend continuing education programs and professional seminars to increase our skills and knowledge of the latest technology, techniques and practice management.

Cancellations

Our primary goal is to assist you in attaining and maintaining optimal oral health. Therefore, your appointment time is reserved exclusively for you. We trust that no change in your appointment will be necessary and we will call you 24 hours in advance to confirm your reserved time. Should an unforeseen circumstance cause you to need to change your reserved appointment, we ask that you give us 24 hours notice.

If you fail to keep an appointment or give less than 24 hours notice for a cancellation, there will be a $50.00 charge.

If you fail to show for two appointments or give less than 24 hours notice for a cancellation, you may be dismissed from the practice.

Changes in Medical History

To protect your health, please advise us of any changes in your medical health history, changes in or addition of prescription/other medication, any surgeries or hospitalizations since your last visit.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

There will be a $25 duplication charge for x-rays and records.

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 wili be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content

_____Date_____ Relationship with Patient:_____

Signature of Patient, Parent or Guardian

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the office *Notice of Privacy Practices.*
Please Print Name

_____
Signature

_____
Date

For Office Use Only

Dr. _____ 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 the Acknowledgment

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