

# PERIODONTOLGY ASSOCIATES OF LEXINGTON

## PATIENT INFORMATION FORM

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	Today's Date:
Birth Date:	Marital status:	Email:
Address:		
Primary Phone:	Secondary Phone:	
I prefer to be contacted by    email    phone    text		
In case of emergency please contact:		Phone:
Who may we thank for referring you?		

Who will be responsible for your account?		Relation:
Driver's License#:	Birth Date:	Phone:
Address:		
Dental Insurance?	Company:	ID# or SS#

DENTAL INFORMATION		
Reason for today's appointment		
When was your last dental exam?	Bleeding gums?	Sensitive teeth?
Food caught between teeth?	If you could change anything in your Smile what would that be?	

*Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.*

Are you under a physician's care now?    Yes    No    If yes, please explain:
Have you ever been hospitalized or had a major operation?    Yes    No    If yes, please explain:
Have you ever had a serious head or neck injury?    Yes    No    If yes, please explain:
Do you use tobacco?    Yes    No    if yes, how much per day?
Do you use controlled substances?    Yes    No
Do you need to pre-medicate?    Yes    No    If yes, please explain:

<b>Women only</b>	Any possibility of pregnancy?
	Expected delivery date?
	Nursing?
	Taking birth control?

MEDICATION HISTORY			
<b>Are you now taking or have taken:</b>			
Nerve pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Killers (including Aspirin) <input type="checkbox"/> Yes <input type="checkbox"/> No	Stimulants ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Relaxers ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Antidepressants <input type="checkbox"/> Yes <input type="checkbox"/> No
Any bone density medications (Boniva, Fosamax, Actonel) .....			<input type="checkbox"/> Yes <input type="checkbox"/> No

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**


**Are you allergic to or had a reaction to:**

Penicillin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Valium or other tranquilizers ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Soy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Latex ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine or other narcotics ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfites ..... <input type="checkbox"/> Yes <input type="checkbox"/> No

**HEALTH HISTORY**

AIDS/HIV Positive ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsion..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis C ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Disorder ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Joint replacement ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Headaches..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble/Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Other ..... <input type="checkbox"/> Yes <input type="checkbox"/> No

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.*

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

Reviewed by Dr. _____	Date _____
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# Periodontology Associates of Lexington

## Consent for Treatment

- A. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
- B. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
- C. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.
- D. I authorize Periodontology Associates to deduct any outstanding balance on my account on my credit card and/or any cancellation fees.

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Parent/Responsible party's signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

## Financial Policy Agreement and Cancellation Policy

The goal of Periodontology Associates is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We want to make certain that our financial policies are clear and understood by you. If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount **up to 60 days**. We will file the appropriate claim forms with your insurance company that you provide us with your personal information including social security number and date of birth. We will also assist you in understanding your dental plan benefits. If your insurance denies coverage, or if we do not receive payment within 60 days from the date services rendered, that amount will then become due and payable by you. Please remember that your coverage is a contract between you, your insurer and/or your employer. Although we will make every effort to help you obtain your benefits, we cannot guarantee your insurance will pay.

## Your payment is due at time of service

Fees for treatment are due at the time treatment is rendered after the deduction of your insurance benefit estimate as described above. Payment options: Cash, Check, Debit Card, Credit Card (Visa and Master Card).

## Patient Responsibility

I acknowledge my responsibility for payment of services rendered by Periodontology Associates in accordance with Periodontology Associates fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on your account is not paid within 30 days of statement, your account will become delinquent and will be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges.

## Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with Periodontology Associates.

## Records/ X-Rays

Periodontology Associates understands that you have the right to request copies of you dental records/x-rays. *We can provide your notes and x-rays with a fee of \$50.00.* We are licensed by the Massachusetts Board of Radiology to take X-rays, and are required by law to keep all original copies of your dental records.

**Initials** \_\_\_\_\_

## Cancellation Policy

Here at Periodontology Associates we understand that interruptions to our schedules can and will occur. We are aware that from time to time most people will encounter some unfortunate circumstances beyond their control. However, our time is scheduled in order to focus upon your oral health concerns. The team at Periodontology Associates makes every effort to make your time at our office pleasant and productive. We take pride in the fact that our appointments are efficient and that you are not subject to lengthy waits in our reception area. All appointments when made have a specific date, time of day, and length of stay, so that you are better able to maximize your time here. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice. We are committed to seeing our patients on time and respecting their time. Late cancellations (less than 48 hours notice) failed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule we request 48 hours notice for cancellations or rescheduling of appointments.

**Acknowledgement of Receipt of Statement of Privacy Practices/Cancellation Policy and Financial Policy**

I acknowledge that I have received a copy of the Statement of Privacy Practices and Cancellation policy for the office of Periodontology Associates. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Periodontology Associates reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Periodontology Associates. We may decline treatment if you revoke this consent.

**Name of Patient:** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_\_\_  
**Signature of Patient:** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_\_\_

**Health Insurance Portability and Accountability ACT**

The HIPAA Privacy Rule creates national standards to protect individual’s medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patient’s privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data-for example, to protect public health.
- For patients-it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections
- It empowers individuals to control certain uses and disclosures of their health information.
- Acknowledgement of receipt of Notice of Privacy Practice You may refuse to sign this acknowledgment.
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I, \_\_\_\_\_, have access to and read a copy of Periodontology Associates Notice of Privacy Practice, and understand my right pertaining to my personal healthcare and insurance information.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Patient’s Signature** **Date**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Witness Signature** **Date**