NATICK DENTAL PARTNERS
Drs. Kane, Soporowski & Mahdavi

230 Pond Street
Natick, Massachusetts 01760
(508) 653-2417

Reviewed By _____ *Date* _____

Patient Information (CONFIDENTIAL)

Name _____ *Home Phone* _____

Birthdate _____ *SS#* _____ *Cell Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Email _____

Check Appropriate Box: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Student, Name of School/College _____ *City* _____ *State* _____ *Full Time* ☐ *Part Time* ☐

Spouse/Partner/Parent/Guardian's Name _____ *Employer* _____ *Work Phone* _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ *Phone* _____

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How much is your deductible? _____ *Max. annual benefit* _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How much is your deductible? _____ *Max. annual benefit* _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?)	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐
d) Have you ever been pregnant?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you ever had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. *We accept cash, personal checks, Mastercard, Visa, Discover, and American Express. As we are providers for Altus, Blue Cross / Blue Shield of Mass, Cigna, United Concordia Elite and Delta Dental (excluding Delta Care, Tufts Delta and Delta's PPO), we will submit claims for payment and ask you for an estimated co-payment at the time services are provided. For all other insurance coverage, we ask for full payment at the date of service and will submit a claim for reimbursement to you. We realize that some procedures are more extensive than others and we will be willing to work out alternative financial arrangements prior to treatment. Please see our billing manager regarding this.*

I have read the above and understand my obligation.

X _____

Signature of patient Date

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE (✓)	CHANGES	PATIENT INITIAL

NATICK DENTAL PARTNERS
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Patient Name _____ Date of Birth _____ Home Phone #_____

Address _____

_____

FINANCIAL POLICY

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. We accept cash, personal checks, Mastercard, Visa, Discover, and American Express. As we are providers for Blue Cross / Blue Shield of Mass, Delta Dental Plan (excluding Delta Care, Tufts Dental, Delta's PPO), Cigna, United Concordia Elite and Altus Dental, we will submit claims for payment and ask you for an estimated co-payment at the time services are provided. For all other insurance coverage, we ask for full payment at the date of service and will submit a claim for reimbursement to you. We realize that some procedures are more extensive than others and we will be willing to work out alternative financial arrangements *prior* to treatment. Please see our billing manager regarding this. In the case of a divorce, the parent bringing the child to the office will be deemed financially responsible.

I have read the above and understand my obligations.

_____

Signature of financially responsible party

In the event that treatment is not paid for at the time services are rendered, an authorization will be required to bill your DENTAL insurance company. Please complete the following so that we will have this on file.

PRIMARY POLICY HOLDER — NAME: _____
SS#: _____

INSURANCE CARRIER: — NAME: _____
MAILING ADDRESS FOR CLAIMS: — STREET: _____
CITY: _____
_____

GROUP / POLICY #:
EMPLOYER OF INSURED: — NAME: _____
ADDRESS: _____

PATIENT ID #: _____

If you have a secondary insurance, please complete the following:

PRIMARY POLICY HOLDER — NAME: _____
SS#: _____

INSURANCE CARRIER: — NAME: _____
MAILING ADDRESS FOR CLAIMS: — STREET: _____
CITY: _____
_____

GROUP / POLICY #:
EMPLOYER OF INSURED: — NAME: _____
ADDRESS: _____

PATIENT ID #: _____

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and am responsible for knowing my plan provisions. I understand that I will be responsible for all copayment, deductible, and rejected charges.

_____

Signature of policy holder

NATICK DENTAL PARTNERS

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Dear Patients and Parents,

At Natick Dental Partners, we understand that you may need to change your existing appointment in our office. If an appointment needs to be canceled and/or rescheduled, we ask you to provide our office with at least 48-hour notice. This will allow our staff to fill the schedule with another patient who may be waiting for this appointment time.

If we receive less that 48-hours notice, a fee equal to the length of your appointment will be charged to your account (i.e. a 45 minute appointment = $45.00). This same fee will also be assessed if you miss an appointment. We do understand and will take into account extenuating circumstances.

Our intent is not to penalize our patients, but to help us provide proper staffing to better meet the dental needs of our patients.

After reviewing our policy, please sign the agreement below.

I have reviewed and understand Natick Dental Partners' *Late Cancellation and Missed Appointment Policy.*

_____ _____

Parent/Patient Signature Date

_____

List name(s) of patients (if under 18 years old)

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INFORMATION REGARDING FILLINGS

White vs Silver

After a thorough comprehensive examination, Natick Dental Partners may recommend a restorative procedure (filling) or several restorative procedures (fillings) for you or your child. Please be advised:

We no longer use silver (amalgam) fillings on primary (baby) teeth due to the substantial improvement in composite/resin (white) filling materials. These new materials have been found to perform better than the amalgam restorations on primary teeth. (We may still recommend, on occasion, silver (amalgam) fillings in certain cases for permanent (adult) molars.)

Please be aware that if your *insurance policy* does not cover composite/resin fillings, your co-payment will be higher. The balance is the patient's responsibility.

Please contact your insurance company for further explanation.

All policies are different and it is very important, if finances are a concern, to file a pretreatment estimate with your insurance company for the treatment plan recommended. We will be happy to do that for you at your request.

In every case Natick Dental Partners will make a recommendation as to the material to use that is in your best interest. Please discuss the treatment beforehand if you have a concern about the recommendation made. We welcome your input.

Name of Patient (Please print): _____

Patient Signature (Over 18): _____

Date: _____