Please use PEN to complete this form.

NATICK DENTAL PARTNERS

Drs. Kane, Soporowski & Mahdavi

230 POND STREET
NATICK, MA 01760
(508) 653-2417
FAX (508) 650-5715

DATE OF RECORD ____________________
REVIEWED BY ____________________

PATIENT INFORMATION FORM

PERSONAL

Patient's Last Name ______ First Name ______ Home Telephone ______ E-mail Address ______ Birth Date ______

Street Address ______ Town ______ Zip ______ Nickname ______ Sex ______

Previous Address if < 3 yrs. at Current Address ______ Town ______ State ______ Zip ______

Parent's Name ______ Cell Phone # ______ Birth Date ______ Social Security # ______ Employer ______

Parent's Name ______ Cell Phone # ______ Birth Date ______ Social Security # ______ Employer ______

Age and Name of Siblings ____________________

PARENT'S INFORMATION: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐ Partners (Check One)

Billing Party ______ Billing Address ______

Parent's Work # ______ Parent's Work # ______

Previous or Family Dentist ______ Telephone ______

Child's Physician ______ Telephone ______

Whom can we thank for referring you ____________________

Address Street ____________________

City ______ State ______ Zip ______ Phone # ______

MEDICAL HISTORY

1. Were there any difficulties during the pregnancy, delivery or first year of the child's life? ☐ Yes ☐ No
   If so, what? ____________________
2. Was your child premature? ☐ Yes ☐ No
3. Is a physician treating your child now for a specific illness? ☐ Yes ☐ No
   If so, for what reason? ____________________
4. Is your child taking any medication at this time? ☐ Yes ☐ No

DRUG	DOSE	FREQUENCY	REASON

5. Has your child taken any unusual medications in the past? ☐ Yes ☐ No
If so, what? ________________ For what reason? ________________

6. Has your child shown any allergies or unusual reactions? Please describe. ☐ Yes ☐ No
a. Medications or drugs ________________
b. Foods ________________
c. Other ________________

7. Has your child ever been hospitalized? ☐ Yes ☐ No
If so, when? ________________
For what reason? ________________

8. Has your child had any operations? ☐ Yes ☐ No
If so, when? ________________
For what reason? ________________
Was general anesthesia used? ☐ Yes ☐ No
Any complications, if so, what? ________________

9. Are your child's immunizations up to date? ☐ Yes ☐ No

10. Does your child have any history of the following diseases or conditions? (if "yes" check boxes that apply) ☐ Yes ☐ No

☐ Rheumatic Fever
☐ Heart Disease
☐ Jaundice
☐ Diabetes
☐ Asthma
☐ Liver Disease
☐ Hepatitis
☐ Tuberculosis
☐ Bleeding Problem
☐ Seizures
☐ Anemia
☐ Past Hx of Child Abuse
☐ Sickle Cell Disease or Trait
☐ Cystic Fibrosis
☐ Leukemia or Tumors
☐ Kidney Disease
☐ Cerebral Palsy
☐ HIV
☐ Heart Murmur, Type? ________________
☐ Learning Disabilities, Type? ________________
☐ Emotional Disabilities, Type? ________________
☐ Hearing Difficulty, Type? ________________
☐ Speech Difficulty, Type? ________________
☐ Developmental Disability or Delay, Type? ________________
☐ Other ________________

11. Does your child bruise easily? ☐ Yes ☐ No

12. Has there ever been any history of spontaneous bleeding (e.g. nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? ☐ Yes ☐ No

13. Does your child see any specialists? ☐ Yes ☐ No

____
Doctor's Name Phone Number Specialty

REMARKS: ________________
____
____

DENTAL HEALTH HISTORY

1. Please check reason(s) for seeking dental care
☐ First examination
☐ Routine check-up
☐ Toothache or swelling
☐ Other ________________
☐ Appearance of teeth or face
☐ Crowding of teeth
☐ Accident

2. If your child has been to a dentist previously ☐ Yes ☐ No
a. When was last visit? ________________
b. Have x-rays been taken and when? Date ________________
c. How would you describe your child's temperament? ________________

3. How do you think your child would react to dental treatment? ________________
____

4. Has your child had fluoride in any of the following forms?
   Fluoride tablets or in vitamins (Fluoride amt. .25 .5 1.0mg) ☐ Yes ☐ No
   Drinking water (community fluoridation) ☐ Yes ☐ No
   Topical application to teeth; last ______
   Toothpaste; brand ______

5. Does your child brush his/her own teeth? ☐ Yes ☐ No
   How frequently and when? ☐ A.M ☐ P.M ☐ After Snacks ☐ Before Bed ☐ After Breakfast.

6. Do you brush your child's teeth? ☐ Yes ☐ No
   How frequently and when? ☐ A.M ☐ P.M ☐ After Snacks ☐ Before Bed ☐ After Breakfast.

7. Do you or your child use dental floss in cleaning your child's teeth? ☐ Yes ☐ No
   How frequently and when? ☐ A.M. ☐ P.M ☐ After Snacks ☐ Before Bed ☐ After Breakfast.

8. Does your child have between meal snacks? ☐ Yes ☐ No

9. Have your child's teeth ever been injured?
   When? ______ Which Teeth? ______ Cause? ______
   Were the teeth treated? ☐ Yes ☐ No
   If so, describe treatment ______

10. Does your child have any of the following habits? (Indicate ages when occurred)
   Bottle to bed at night ______
   Thumb or finger sucking ______
   Pacifier ______
   Tongue thrusting ______
   Lip sucking or biting ______
   Breathes through mouth ______

11. Has your child received any unusual dental or surgical treatment to the mouth? ☐ Yes ☐ No
   If so, what? ______

I hereby give permission to Natick Dental Partners to provide to my child dental treatment which the doctor deems necessary and appropriate. Routine treatment may include but not be limited to: topical anesthetic, periodic radiographs, local anesthetics a(injections), etc.

Signature of Legal Guardian ______ Date ______

RE-EVALUATION OF ORIGINAL MEDICAL HISTORY PORTION OF THIS FORM

Has there been any change in patient's health and/or medications since last dental appointment? If yes please describe below.

DATE	NO CHANGE (✓)	CHANGES	PARENT INITIAL

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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#: ______________________

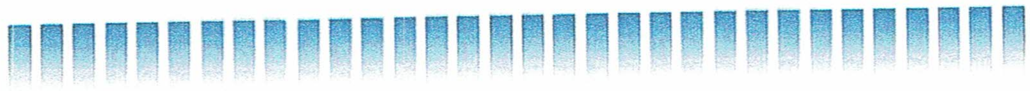
INSURANCE CARRIER: NAME: ______________________
MAILING ADDRESS FOR CLAIMS: STREET: ______________________
CITY: ______________________

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.

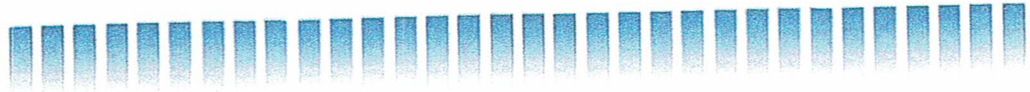
I have reviewed and understand Natick Dental Partners' *Late Cancellation and Missed Appointment Policy.*

____________________________ ______________________

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: ____________________