Craig Macdonald DMD

PATIENT INFORMATION

Patient______________________________Date______________________

Nickname______________________DOB __________ Age ______Sex ☐ M ☐ F

Home Address____

Home Phone______________________Cell Phone______________________

E-mail ______________________Social Security # ______________________

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered

Occupation ____

Employer______________________________Work Phone__________________

Employer Address ____

Spouse's Name____

DOB ______________________________ Cell Phone______________________

Employer______________________________Work Phone______________________

Whom may we thank for referring you to us?______________________________

In Case of Emergency, contact (please specify someone who does not live in your household)

Name______________________________Relationship______________________

Cell Phone______________________________Work Phone______________________

CONSENT FOR DENTAL TREATMENT

You have a right to accept or reject dental treatment. Prior to consenting you should consider the benefits and risks of the procedure, alternative treatments or the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Small risks may include swallowing or inhaling of saliva or dental materials, discomfort, bleeding, post numbing bite trauma, bruising, swelling, numbness or allergic reaction. The dentists (Dr. Jolanta Macdonald, Dr. Craig Macdonald, and Dr. Anita Bhatt) do everything possible to minimize or completely prevent these risks and side effects. I understand that drugs and medications including antibiotics, analgesics and other medicines can cause allergic reactions causing redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction). By signing this consent you are allowing the dentists at Children's Dentistry of Northborough to diagnose and treat you.

I consent to receive cleanings, dentist examinations, fluoride treatment, photographs, and x-rays. Should I agree to a treatment plan, I consent to allow the providers at this office to do sealants, fillings and other common dental procedures within the standards of care for the duration of my time as a patient. If I wish not to consent to any of the above I agree to inform the dentist the day of my appointment.

Signature ____ Date ______________________

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HEALTH HISTORY

Name of physician ______________________________ Date of last physical exam ____________________

Please check if you have been treated for any of the following:

☐ AIDS/HIV	☐ Circulatory Problems	☐ Hepatitis Type ____	☐ Rheumatic Fever
☐ Anemia	☐ Congenital Heart Lesions	☐ Herpes	☐ Shortness of Breath
☐ Arthritis	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valves	☐ Persistent Cough	☐ Frequent infections	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaundice	☐ Special Diet
☐ Asthma	☐ Emphysema	☐ Kidney Disease	☐ Stroke
☐ Back Problems	☐ Epilepsy	☐ Liver Disease	☐ Swollen feet/ankles
☐ Bleeding Abnormally	☐ Fainting/Dizziness	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Nervous Problems	☐ Tuberculosis
☐ Cancer	☐ Headaches	☐ Psychiatric Care	☐ Tumor head/neck
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Weight Loss	☐ Contact Lenses	☐ Pregnant	☐ Nursing

Please elaborate on any items checked: ____

____

☐ Yes ☐ No Have you ever been hospitalized? Please give reason and dates: ____________________

____

☐ Yes ☐ No Have you had any operations? Please give reason and dates: ____________________

____

Medications

☐ Yes ☐ No Are you currently taking any medications? Please give medication, doses, and reason:

____

____

Allergies

☐ Aspirin	☐ Local anesthetic	☐ Barbiturates (Sleeping pills) ‘	Codeine
☐ Penicillin	☐ Sulfa	☐ Iodine	☐ Latex

☐ Other ____

Comments ____

____

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DENTAL HISTORY

Reason for today's visit: ____________________

____

Former dentist ____________________

City/State ____________________

Date of Last Dental Visit ____________________ Date of Last Dental X-Rays ____________________

Please check if you have had any of the following:

☐ Bad Breath ☐ Dry Mouth ☐ Broken Fillings

☐ Bleeding Gums ☐ Fingernail Biting ☐ Cavities

☐ Blisters Lips/Mouth ☐ Food Impacted Btw Teeth ☐ Mouth Breathing

☐ Burning on Tongue ☐ Grinding Teeth ☐ Mouth Pain

☐ Chew on one side ☐ Gums swollen/tender ☐ Orthodontic Treatment

☐ Cigarette Smoking ☐ Jaw Pain ☐ Periodontal Treatment

☐ Pipe or Cigar Smoking ☐ Jaw Clicking ☐ Sores in Mouth

☐ Lip/cheek biting ☐ Loose Teeth ☐ Sensitivity to Cold

☐ Sensitivity to heat ☐ Sensitivity to Sweets ☐ Sensitivity to Biting

How often do you brush? ____________________

☐ Yes ☐ No Do you use an electric toothbrush? Type: ____________________

How often do you floss? ____________________

☐ Yes ☐ No Are you interested in tooth whitening? ____________________

☐ In Office Whitening ☐ Tray take home whitening ☐ Both

☐ Yes ☐ No Are you anxious during dental appointments? Why? ____________________

____

Comments: ____________________

____

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drmacdonald@mychildrensdentist.com

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INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Subscriber Name: ____________________ SS#: ____________ D.O.B. ____________

Employer Name: ____________________

Employer Address: ____________________

Insurance Company: ____________________ Phone #: ____________

Insurance Address: ____________________

Subscriber#: ____________ Group# (if applicable): ____________

SECONDARY DENTAL INSURANCE

Subscriber Name: ____________________ SS#: ____________ D.O.B. ____________

Employer Name: ____________________

Employer Address: ____________________

Insurance Company: ____________________ Phone #: ____________

Insurance Address: ____________________

Subscriber#: ____________ Group# (if applicable): ____________

Financial Policy Regarding Payment and Insurance

We thank you for paying for treatment on the day that services are rendered. As a courtesy to our patients with dental insurance, we will file an insurance claim for payment. Please be aware that dental insurances have co-pays, deductibles, or fees that are not covered. Many routine preventive services are covered in full, but most plans will only pay for portions of orthodontic and restorative treatments. We will expect payment for the portion of treatment that is not covered by your insurance on the day of service. We accept cash, check, credit and debit cards. Payment plans can be set up through Care Credit for those in need of an extended payment option.

There are many dental plans and we are unable to know the specifics for all. We try to assist you by getting a pre-estimate from your insurance company prior to treatment. Should you chose to complete dental treatment prior to receiving the pre-estimate we will collect an estimation of what we feel is due and will refund you any money that was overestimated or bill for what was not collected on the day of service. We ask that you familiarize yourself with your dental plan and the benefits you have. This can help you to avoid unexpected bills. Please remember, even if you have insurance, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured, and your insurance company. Please inform us if your insurance has changed. We are here to help you answer any insurance or billing questions you may have.

Pre-Treatment Authorization: We will obtain a pre-treatment authorization from your insurance company. This is an estimate regarding your dental deductible and co-pay. Please be aware that treatment recommendations may change due to the progressive nature of dental disease.

Fillings: Our office only uses white (composite) fillings. Please be aware that your insurance company may not pay for a white filling at the same level as a silver (amalgam) filling. The difference is your responsibility.

Missed Appointments: We ask that you provide us with at least 24 hours notice to cancel or reschedule any appointment so that we may use that time for another patient. If you do not provide us with a 24 hour notice, a cancellation fee will be applied to your account. This fee will vary depending on the length of your appointment. Appointments are confirmed by email. Please make sure we have an accurate email address on file. You may also opt in for text message confirmations.

Past due accounts: Past due accounts are subject to a monthly service charge and will be turned over to the collection agency or small claims court. You agree to pay any and all attorney fees associated with the collection of monies due.

Returned checks: There is a $30.00 charge for all checks returned by your bank for any reason.

Copy of records: There is a charge for the copy of X-rays.

I authorize my provider to release information regarding dental treatment to my insurance company for payment directly to the dentist for services rendered. I understand I will be responsible for all co-payments, deductibles, and rejected charges. I have read the above and understand my financial obligations.

Signature: ____________________ Date: ____________