SOUTH BOSTON DENTAL GROUP

sbdg@southbostondental.com
9 Channel Center Street, Boston MA 02210
617-268-1030

NEW PATIENT FORMS

Patient Name: _____ Gender Identity: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Check appropriate box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Patient/Parent/Guardian's Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Who may we thank for referring you? _____

RESPONSIBLE INSURANCE PARTY

Name of person responsible for this account: _____ DOB: _____

Relationship to patient: _____ Email: _____ Patient at the office? ..... Y ☐ N ☐

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to patient: _____

DOB: _____ SSN: _____ Best Contact Number: _____

Name of Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance: _____ Group #: _____ Policy ID: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

DO YOU HAVE A SECONDARY DENTAL INSURANCE? ..... Y ☐ N ☐ If yes, please complete the following:

Insurance: _____ Group #: _____ Policy ID: _____

Thank you for selecting our dental healthcare team! If you have any questions or need assistance, please ask us – we will be happy to help.

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MEDICAL HISTORY

Patient Name: _____ Phone Number: _____ DOB: _____

Physician: _____ Office Phone: _____ Date of Last Exam: _____

CURRENT HEALTH STATUS

Are you under medical treatment now? ..... Y ☐ N ☐

Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? ..... Y ☐ N ☐

If yes, please explain: _____

_____

Are you taking any medication(s)? ..... Y ☐ N ☐

If yes, please list: _____

Do you use tobacco? ..... Y ☐ N ☐

Do you use controlled substances? ..... Y ☐ N ☐

ALLERGIES

Are you allergic to or have reactions to the following:

Local Anesthetics ..... Y ☐ N ☐

Penicillin or Antibiotics ..... Y ☐ N ☐

Aspirin ..... Y ☐ N ☐

Codeine ..... Y ☐ N ☐

Metals ..... Y ☐ N ☐

Latex ..... Y ☐ N ☐

Others

_____

REPRODUCTIVE HEALTH

Current or potential pregnancy? ..... Y ☐ N ☐ Are you nursing? ..... Y ☐ N ☐ Are you taking oral contraceptives? ... Y ☐ N ☐

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

Tuberculosis ..... Y ☐ N ☐

Low Blood Pressure ..... Y ☐ N ☐

High Blood Pressure ..... Y ☐ N ☐

Cancer ..... Y ☐ N ☐

Type? _____ When? _____

Radiation/Chemo ..... Y ☐ N ☐

Heart Problem(s) ..... Y ☐ N ☐

Pacemaker ..... Y ☐ N ☐

Asthma/Respiratory ..... Y ☐ N ☐

Ulcer(s) ..... Y ☐ N ☐

Kidney Problem(s) ..... Y ☐ N ☐

Liver Problem(s) ..... Y ☐ N ☐

Bleeding Disorder(s) ..... Y ☐ N ☐

Stroke ..... Y ☐ N ☐

Diabetes ..... Y ☐ N ☐

Hepatitis/Type ..... Y ☐ N ☐

Emphysema ..... Y ☐ N ☐

Sinus Problem(s) ..... Y ☐ N ☐

Venereal Disease ..... Y ☐ N ☐

HIV/AIDS ..... Y ☐ N ☐

Glaucoma ..... Y ☐ N ☐

Epilepsy/Seizures ..... Y ☐ N ☐

Plates, pins, screws or artificial joints/replacements ..... Y ☐ N ☐

Orthopedist name & number

_____

_____

Are you required to pre-medicate before any dental treatment? ..... Y ☐ N ☐

AUTHORIZE & 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 or my child during the period of such Dental Care to third party payors 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 or my dependents.

Patient/Guardian Signature: _____ Date: _____

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POLICIES FOR SOUTH BOSTON DENTAL ASSOCIATES

In an effort to avoid any misunderstanding, we would like you to review our financial and office policies before you begin treatment in our office. Standard of care in this practice requires full mouth X-rays every 5 years and bitewing X-rays and exam by a doctor every year. **We will not treat patients without updated X-rays.**

Payment is expected at the time services are performed. We accept all major credit cards. For extensive services we offer low and no interest payment plans through Care Credit.

FOR OUR PATIENTS WITH DENTAL INSURANCE, OUR POLICY IS AS FOLLOWS

You will need to supply us with the subscriber's name, date of birth, social security number, employer, and ID # as well as the name and address of the insurance company. We will do our best to answer any questions you may have about your insurance coverage but we always suggest that you call or visit your insurance company's website.

As a courtesy to our patients, we will gladly submit the insurance claim to your insurance company. We will collect your estimated co-payment and deductible at each visit. We make every effort to determine your insurance benefits when you receive treatment, but consider your co-payment and estimate until we receive payment from your insurance company.

Please remember that any information we provide relative to your insurance coverage is our best estimate and NOT a guarantee of the payment that will be received.

APPOINTMENT POLICY

We reserve appointment times specifically for each patient so that we may provide the ultimate service. Please schedule your appointment carefully as there will be a charge to your account for any appointment cancelled without a 24 hour notice. Similarly, late arrivals can create scheduling problems with other patients. Please notify us if you are going to be late.

If you have any questions about any of our policies, please feel free to ask any member of our staff.

Patient/Guardian Signature: _____ Date: _____

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INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist or hygienist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

I understand that during my course of treatment that the following care may be provided:

1. **Treatment To Be Provided**

   – Examinations – Crowns – Bridges
   – Preventative Services – Restorations – Other

   Patient Initials: _____

2. **Drugs and Medications**
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that delivery of local anesthesia may result in (but not limited to) cardiovascular response, anaphylactic reaction, or paresthesia.

   Patient Initials: _____

3. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative work. If this occurs we will inform you of the change before treatment is completed.

   Patient Initials: _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

   Patient Initials: _____

Patient Signature: _____ Date: _____

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HIPAA PRIVACY STANDARDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SOUTH BOSTON
DENTAL GROUP
BY OSORIO DENTAL

I have received a copy of this
office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

You May Refuse to Sign This Acknowledgement of Receipt.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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PATIENT CONSENT FORM FOR E-MAIL USE

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Email Address _____

South Boston Dental Associates offers patients the opportunity to communicate with our organization and Providers by e-mail. Transmitting patient information by e-mail however has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

- E-mail can be circulated, intercepted, altered, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.
- E-mail senders can misaddress e-mail.
- E-mails are archived, stored and inspected through system audits.
- E-mail can be used to introduce virus into computer systems.
- E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL

We will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outline above, we cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by our organization.

We will not use e-mail communication for matters that may be unlawful or contain sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability, or substance abuse.

INSTRUCTIONS: To communicate by e-mail, we will request that the patient shall:

- Limit or avoid use of employer's computer.
- Keep the email concise, do not use for sensitive information (regarding STD's, substance abuse, mental health or HIV/AIDS)
- Inform us of any changes in e-mail address.
- Include your name in the body of the e-mail.
- Include specific category in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear, specific and contains relevant information before sending to our organization.
- Restricted communications from the patient must be provided if applicable.
- Withdraw e-mail consent at any time by e-mail or written communication to our organization or Provider.
- E-mail will not be used for urgent or emergency situations.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT E-MAIL USE

I acknowledge that I have read and fully understand this e-mail consent form. I understand the risks associated with the communication of e-mail between the organization and my Provider, and consent to the conditions outlined above. In addition, I agree to the instructions outlined as described, as well as any questions I may have had were answered.

Patient/Guardian Signature: _____ Date: _____

Orthodontist Signature: _____ Date: _____