O'TRAFFORD
DENTAL SPECIALISTS

388 Commonwealth Ave, Unit B-1• Boston, MA 02215
Phone: 617-859-8000 • Fax: 617-859-8001
info@otrafforddental.com • www.otrafforddental.com

Welcome

Every day, we strive to ensure that all patients are provided with optimum periodontal and personal care; because **WE** care!

Health Information

Before we start your treatment, we need some brief information on your medical history, which may affect your treatment. All information is confidential.

Patient Name: _____Date of Birth:_____ Last Primary Doctor Visit: _____ Primary Doctor's Name & Phone #: _____Reason for today's visit? _____

Work Related Injury? (circle) **Yes** **No**

Have you been under the care of a physician? (circle) **Yes** **No**

Have you ever been hospitalized? (circle) **Yes** **No**

Height: _____Weight: _____

General Dentist's Name: _____ Date of last dental visit:_____ Date of last dental x-rays:_____ Date of last cleaning:_____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes** **No**

Ever had Novocaine or other local anesthetic? (circle) **Yes** **No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) Yes No

Are you taking or have taken Oral Bisphosphonates? (e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, ZOMETA, AREDIA) (circle) **Yes** **No**

Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes** **No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics,

latex, metals, or any other medication? (circle) **Yes** **No**

List any medications you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____ .

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____.

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Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Asprin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Excessive Bleeding			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures, which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature_____Date_____

Medical History Review_____Date_____

6 months Update ->

Patient's Signature_____Date_____

Medical History Review _____Date_____

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Patient Information

Circle One: Dr / Mr / Mrs / Ms / Miss

First: _____Middle: _____Last: _____ Jr/Sr: _____

Street: _____ City: _____State:_____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____

Email Address: _____

May we contact you by email? (circle) **Yes** **No**

May we send you appointment reminders by text? (circle) **Yes** **No**

Patient Social Security Number:_____ Patient Date of Birth: _____Sex: (circle) **M** **F**

Emergency Contact:_____ Phone: _____

Preferred Pharmacy_____ Pharmacy Location: _____

How did you hear about us? (circle) Newspaper Radio TV Internet Referral Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes** **No** Do you have Secondary Dental Insurance? (circle) **Yes** **No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card to our patient services representative to be photocopied			

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In regards to sharing my information with my general dentist and or my primary doctor, I authorize the disclosure of information from my treatment records.

I give authorization to disclose the following information: (Check Mark)

_____All treatment information

_____Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying my O'Trafford Dental Specialists practice in writing.

Signature of Patient (or Patient Representative) _____

Date: _____

Printed Name of Patient (or Patient Representative) _____

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HIPAA CONSENT FORM

Health Insurance Portability and Accountability Act

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations and specialist consultation.

You may obtain a copy of our Notice of Privacy Practices by contacting the office of:

O'Trafford Dental Specialists

388 Commonwealth Ave, Unit B-1

Boston, MA 02215

617-859-8000

I, _____, have had full opportunity to read and consider the contents of this Consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, health care operations and specialist consultations.

Patient Name:_____ Date of Birth:_____

Signature:_____

Today's Date:_____

Parent/Guardian:_____ Relationship to Patient:_____

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ASSIGNMENT AND RELEASE

I, the undersigned, with (*Name of Insurance Company*)_____ , assign directly to O'Trafford Dental Specialists all benefits, if any, otherwise payable to me for services rendered. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient's Name: _____

Signature:_____

Date:_____

MINOR/CHILD CONSENT

I, being the parent or guardian of_____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Insured/Guardian:_____

Date:_____

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FINANCIAL AGREEMENT

1. I understand and accept that I am responsible for all payments whether the treatment is covered by insurance or not.

2. I understand that my insurance contract is between the insurance company, my employer and me. Any efforts to collect payment from the insurance company will be handled as a courtesy by the dental office.

3. I understand that insurance coverage costs quoted to me are ESTIMATES of what my insurance company may pay.

4. I understand that all remaining balances not paid to O'Trafford Dental Specialists in a timely manner are subject to a finance charge of 1% per month on overdue accounts.

5. I am aware the delinquent accounts may be turned over to collections if payment arrangements are not made and I am responsible for any costs incurred.

6. I understand my insurance coverage that has been explained to me.

I HAVE READ, UNDERSTAND AND ACCEPT THE 6 FINANCIAL AGREEMENT TERMS LISTED ABOVE.

Patient's Name: _____

Signature Insured/Guardian:_____
Date: _____

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CHECK RETURN FEE

I understand that if I write a check to O'Trafford Dental Specialists for payment of treatment or services rendered and the check is returned for insufficient funds, I am still responsible for the payment due (which must be made in the form of cash or money order) as well as an additional $25.00 check return fee.

Signature Insured/Guardian:_____ Date:
_____

CANCELLATION POLICY

We want to thank you for choosing our practice to provide you with your dental care needs. In order to give you and all of our patients the best care possible, we request that you review our policy regarding missed/cancelled appointments.

A missed appointment is when a patient does not show up for the time we have put aside for treatment without a phone call no less than 24 hours prior to the appointment time or in case when appointment is confirmed yet the patient is a No Show. **We will charge a fee of $50 for missed appointment.**

O'Trafford Dental Specialists thanks you for your understanding regarding this matter.
Please sign below to assure you have read and understand the policy.

_____
Patient's Name

_____
Signature

_____
Date