388-390 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? (Check one) **Yes** ☐ **No** ☐

Have you been under the care of a physician? (Check one) **Yes** ☐ **No** ☐

Have you ever been hospitalized? (Check one) **Yes** ☐ **No** ☐

Height: _____Weight: _____

General Dentist's Name: _____ Date of last dental visit: _____

Date of last dental xrays: _____Date of last cleaning: _____

Have you ever been treated for periodontal (gum) disease? (Check one) **Yes** ☐ **No** ☐

Ever had Novocaine or other local anesthetic? (Check one) **Yes** ☐ **No** ☐

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

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

Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (Check one) **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? (Check one) **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
Any Type of Implants			Epilepsy or Seizures			Lung Disease			Asthma		
Pain in your jaw (TMJ)			Allergies or Hives			Kidney Disease			Anemia		
Mitral Valve Prolapse			Art type of Transplant			Liver Disease			Arthritis		
Teeth Grinding/Cleanching			Chemotherapy			Thyroid Disease			Dialysis		
Fainting or Dizzy Spells			Rheumatic Fever			Venereal Disease			Stroke		
Ulcers of Stomach Problems			Tuberculosis(TB)			Heart Murmur			Diabetes		
Aspirin/Anticoagulant Therapy			Blood Transfusion			Radiation Treatment			Cancer (type:)		
Any Artificial Hip, Knee or other Joint			High Blood Preasure			Excessive Bleeding			Alcoholism		
Pace Maker/Heart Surgery			Low Blood Preasure			Latex Allergy			Other Disease or Illness:		
Psychiatric Treatment			HIV Positive/AIDS			Sinus Problems					
Heart Problem ( )			Hepatitis (type:)			Drug Addiction					
Use of Tobacco Products			Breathing Problems			Mouth Sores/growths					

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 penocillin) may alter the affectiveness 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

(Check 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? (Check one) **Yes** ☐ **No** ☐

May we send you appointment reminders by text? (Check one) **Yes** ☐ **No** ☐

Patient Social Security Number: _____

Patient Date of Birth: _____ Sex: (Check one) **M** ☐ **F** ☐

Emergency Contact: _____ Phone: _____

Preferred Pharmacy _____

Pharmacy Location: _____

How did you hear about us? (Check one) Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Referral ☐

Other: _____

Insurance Information

Do you have Dental Insurance? (Check one) **Yes** ☐ **No** ☐

Do you have Secondary Dental Insurance? (Check one) **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 #	
Insuranse Phone #		Insuranse Phone #	
* Please present your insurance card to our patient services representative to be photo copied*			

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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. 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