

Email Address: _____

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Thyroid
	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Growths	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tumors
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Ulcers
		Due date: _____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Fever	OTHER:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> _____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stomach Problems	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease		

• Are you taking any medication, drugs or pills now? Yes No Please list _____

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Richard Lewis D.M.D

281 Cambridge Street
Burlington, MA 01803
781 272 5890

PAYMENT POLICY

Thank you for choosing us as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service possible. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that your (or your family members) receive treatment. Please indicate below your preferred method of payment.

My preferred payment option is:

- Cash
- Check
- Major credit card (Visa, MasterCard, Discover)
- ***

A note for patients with dental insurance

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can **estimate** the amount of your co-payment. Your co-payment is expected when treatment is delivered. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

***For treatment amounts over \$300, please inquire about the possibility of an extended payment plan.

Acceptance Agreement

I understand and agree with the above financial policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party _____
Printed name

Signature

Date

Dr. Richard Lewis
Dr. Louis Bruno
281 Cambridge St.
Burlington, MA 01803

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

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

Please Print Name

Signature

Date

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)

