DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Framingham Premier Dental
Marianna Gaitsgory, DMD
Family & Cosmetic Dentistry
55 Main St., Suite 2
Framingham, MA 01702
Telephone: (508) 875-0900

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s) _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex _____
- ☐ Other _____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

FRAMINGHAM PREMIER DENTAL

Marianna Gaitsgory, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES (HIPPA)

I, _____ acknowledge that I have received a copy of Framingham Premier Dental's notice of Privacy Practices. This Notice describes how Framingham Premier Dental may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_____

Signature of Patient or Personal Representative Date

_____

Relationship to Patient

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify Below)

_____

_____

_____

FRAMINGHAM PREMIER DENTAL

Marianna Gaitsgory, D.M.D.

Office Policies

Financial Agreement – Effective 1-1-2011

As a courtesy to our patients, we will verify dental benefits and submit charges to your insurance company. However, it is ultimately the **patient's responsibility** to know what your insurance covers. Dental Insurance is designed to cover a portion of your fees only. Your estimated copay is collected at the time services are rendered. In the event your insurance does not pay on the claim, **you are responsible for the payment** when you receive a statement from our office.

Self-Pay Patients Payment Policy

We are happy to offer a senior discount at age 65 and over of 10% if payment is made in full at the time services are rendered. If you do not pay the same day, the discount does not apply. We also offer a 10% discount on major work over $400.00 which is paid in full at the time the services are rendered when paid with a check or cash. Should any check be returned for non-sufficient funds by the bank to us will be subjected to a $25.00 fee.

Cancellation and Failure to Arrive

Please understand we are reserving appointment time for you as well as for the doctor and our hygienists. There will be a **$45.00 Cancellation Fee** for every appointment missed or canceled less than 48 hours in advance, unless there is a reasonable excuse.

Duplication of X-Rays

Original x-rays are the property of Framingham Premier Dental. If you wish to have your x-rays duplicated, you will need to sign a medical release and pay a processing fee of $25.00, as well as any balance on the account. A notice of 72 hours is required prior to picking up or mailing out x-rays.

Collections

Patients with outstanding balances will be sent a statement. If no payments are made within 30-60 days, it may become necessary to involve a third party collections agency. In this case patient will be responsible for all lawyer or agency's fees originated by collection efforts or any dispute.

By signing below, I understand and agree to the above listed office policies and assume responsibility for all services rendered.

_____ _____

Signature of Patient Date

_____

Printed Name