



Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be happy to help you.

ADULT PATIENT MEDICAL/DENTAL HISTORY FORM

Name: _____ Birthdate: _____ Gender (M / F/ other) _____

Billing Address: Street: _____
 City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

I consent to receive texts, emails and cell phone confirmations for my appointments. I allow Duxbury Children's Dentistry to leave messages for me at the telephone numbers and email I have provided. _____(Initial here)

Do you consent for us to share treatment plan and financial information with your parents? (YES / NO) _____Initial
 Do you consent for us to share prescription or referral suggestions with your parents? (YES / NO) _____Initial

DENTAL INSURANCE INFORMATION:

My dental insurance is through my parents and has not changed _____ (Initial if True)
 Do you have dental insurance through your own job (Yes / No) Employer: _____

Person Responsible for Payment on Account: _____

Primary Insurance: (if different than what is on file) _____ SECONDARY INSURANCE (enter here) _____
 Subscriber Name: _____
 Group/Policy#: _____
 Insurance Company: _____

Social Security Number of insured: _____ DOB of insured: _____
 Signature of Insured Person (if you): _____

MEDICAL HEALTH HISTORY:

Date of last Physical: _____ Physician: _____

Current Medications/Hormones/Vitamins: _____
 Any Dental Complaints? _____ Do you brush twice daily? (Y / N) _____ Do you floss? (Y / N) _____

Allergies: (list all) _____
 Do you use any tobacco products (confidential information)? (Y / N) Please List: _____
 If so, are you interested in us helping you quit? (Y / N) _____

Past Surgeries: _____ Hospitalizations? _____

Do you have any of the following? Grinding or nail biting habit? (Y / N) History of Trauma to Face or Teeth? (Y / N)
 Sensitive Teeth? (Y / N) Dental Anxiety (Y / N) Do you play sports without a mouthguard? (Y / N)

<u>Have you been diagnosed or treated for:</u>	Yes	No		Yes	No
A.I.D.S./H.I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Autism / Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune	<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding/Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots/Dyscrasias	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Social Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Impairment	<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>

Please describe "Yes" or "Other"

CONSENT TO DENTAL TREATMENT:

The dentists (Dr. Joy John, Dr. Kierstin Kerr, Dr. Amanda Peer, Dr. Lauren Murphy) and staff at Duxbury Children's Dentistry do everything possible to minimize or completely prevent risks and side effects. You have a right to accept or reject dental treatment. Prior to consenting you should consider the benefits and risks of the procedure (ask for full description of procedure prior), alternative treatments or the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Procedure risks may include swallowing/inhaling of saliva or dental materials, pain or sensitivity, damage to adjacent tooth/filling/sealant material, bleeding, inflammation, infection, allergy and/or reaction to dental materials. Risks for fillings or extractions may also include nerve exposure, tooth fracture, bruising, bite trauma after numbing, temporary or permanent numbness, and/or reaction to local/topical anesthetics. Most of these are uncommon, but patients should be aware prior to providing consent.

By signing this consent form you are allowing any of these dentists to treat your dental needs while you are a patient at our office.

1. I consent to receive cleanings, dentist examinations, fluoride treatments and x-rays. Should I agree to a treatment plan, I consent to allow the providers at this office do sealants, fillings, and other common procedures within the standards of care for the duration of my time as a patient at Duxbury Children's Dentistry. If I wish not to consent to any of the above I agree to inform the dentist on the day of my appointment and prior to the start of the appointment. I understand that this consent remains in effect while I am a patient of the office.

2. I understand that drugs and medications including, but not limited to, antibiotics, analgesics, and local anesthetics can cause allergic reactions causing redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction)

Patient Signature: _____ **Print Name:** _____ **Date:** _____

Doctor/Provider Signature: _____ **(for consent and medical history) Date:** _____

OFFICE FINANCIAL POLICY:

I agree that payments/co-payments are due the day of a procedure. I agree to have payment arranged from the responsible party. I agree that my dental benefits may only cover portions of my bill and that the remaining amount will be either my responsibility or the responsibility of my parents. I understand that it is my responsibility to ensure that I have insurance coverage and to make sure that my insurance information is up-to-date. I understand that I am responsible for knowing the details of my insurance plan including deductibles, maximum allowances, eligibility and estimated co-payments. Late fees are charged to accounts over 90 days. The maximum amount is \$35.00 per month unless the account is eligible for a collection fee.

Broken Appointment Policy: We reserve the right to charge a fee for missed appointments . The fee for a missed appointment with the doctor is \$80.00 and the fee for a missed appointment with a hygienist is \$30.00. These fees are subject to change. Please make every attempt to reschedule appointments with more than 24 hours of advanced notice. Insurance Companies do not cover the cost of Nitrous Oxide, Silver Diamine, or Record Transfer fees. Please be aware that a fee will be charged for these services.

I authorize my insurance provider to pay Duxbury Children's Dentistry directly. I understand that I am responsible for knowing the benefits of my insurance plan. I understand I am responsible for all fees including, but not limited to co-payments, deductibles and rejected charges. There may be a charge for the transfer of dental records (see our website for more information).

Patient Signature: _____ **Print Name:** _____ **Date:** _____

Disclosure of Health Information, Patient Rights and HIPAA:

Health information may be used/disclosed for the purpose of treatment, payment, and healthcare operations. We may disclose your information to a healthcare provider treating you. You may give us authorization to disclose health information to anyone (including yourself) for any purpose. Such authorization may be revoked in writing. Your written permission, before any health information may be disclosed, is required. In the event of an emergency, we will disclose information regarding your treatment based on our professional judgment. Your health/dental information may be used to obtain payment for services from your parents (if they are responsible for the bill) or your insurance company. As required by law if we suspect the possibility of abuse, neglect, or domestic violence , we may disclose your health information. Your information may be disclosed in our attempts to provide you with appointment reminders and/or treatment recommendations (i.e. voicemails on cell and home phone, postcards, letters, etc.) Information regarding your health will not be used for marketing purposes without your prior written consent.

You have the right to obtain copies of your health/dental records and radiographs. You have the right to request that additional restrictions be placed on our use or disclosure information. You have the right to request that we communicate with you about your health history by alternative means and at other locations. You have the right to request that we amend your dental or health information. Under certain circumstances, we may deny such a request. In the event that you are concerned that we may have violated your privacy/right or you disagree with a decision we made about access to your health information, or if you disagree with our response to your request to change your health information, you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please contact Dr. Joy John or Dr. Kierstin Kerr.

A personal copy of our Notice of Privacy Practices is available at the front desk as well as on our website for all patients . I, _____, have been offered a copy of the Duxbury Children's Dentistry Notice of Privacy Practices.

Patient Signature: _____ **Print Name:** _____ **Date:** _____