DATE 4/8/2021

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Emergency Contact _____

Emergency Phone # _____

Address _____

City/State _____

Phone #2 _____

Relationship _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Time 10:32 AM

Lakeville Dental Associates

Date 1/18/2021

NEW MEDICAL HISTORY 9/2019

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you currently taking Coumadin, Warfarin, Eliquis, Plavix or any other blood thinner?	◯ Yes ◯ No	If yes	
Have you ever been told you need to premedicate with antibiotics prior to dental treatment?	◯ Yes ◯ No		
Do you have any dental problems?	◯ Yes ◯ No	If yes	
Are you happy with your smile?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Ibuprofen	☐ Clindamycin		

Any other Allergies not listed above?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Are you Taking any Medications? If Yes, Please list:	◯ Yes ◯ No		

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psyhiatric Care	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Cold Sores/ Fever Blisters	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No

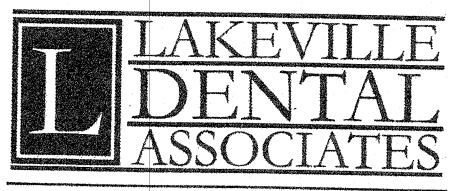
Any other medical conditions not listed above:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____



54 Main St. Suite #6 Lakeville, MA 02347
Phone: (508)923-6900 Fax: (774) 213-9689
lakevilledental54@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

Print name: _____

Signature _____

Date _____ / _____ / _____

_____ For Office Use Only _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the 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) _____
_____

LAKEVILLE DENTAL ASSOCIATES

SUPPLEMENTAL
INFORMED CONSENT

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have undertaken measures to accommodate social distancing in our practice, due to the nature of the procedures we provide, it is not possible at all times to maintain social distancing between the patient, the dentist, the clinical staff, and on occasion, among other patients.

By checking "**Yes**" below, I am hereby acknowledging that I understand that by receiving treatment in your office there is a risk of exposure to the Coronavirus; I have considered that risk of exposure to the Coronavirus and, after careful deliberation, I hereby accept that risk and I hereby consent to treatment in your office

By checking "**No**" below, I do not consent to receiving treatment in your office and I understand that absent my consent you will not provide me with treatment in your office

☐ Yes ☐ No

_____
Print Name

_____ _____
Patient/Guardian's Signature Date