Dolce Dental, PC

dolcedentalsmiles.com
frontdesk@dolcedentalsmiles.com
100 Wendell Ave. • Pittsfield, MA 01201
(413)442-6643

Welcome to Dolce Dental, PC

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter Name & Phone # below:

_____

_____

How may we contact you for appointment reminders? Check all that apply.

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text Message ☐ Email

Primary Dental Insurance Card Holder

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Subscriber Social Security Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all changes whether or not paid by insurance.

Secondary Dental Insurance Card Holder

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Subscriber Social Security Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all changes whether or not paid by insurance.

Medical History

- [ ] *Pre-Med -Amox
- [ ] *Pre-Med -Clind
- [ ] *Pre-Med -Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy -Atibiotics
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] HIV
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please list other:

_____

_____

_____

_____

Please discribe Allergies:

_____

_____

Do you take Premedication (Antibiotics) for your Dental visits? If yes, Please list & explain: *

_____

_____

Review of Symptoms (check if yes):

Allergy/Immunology:

- [ ] Sneezing
- [ ] Runny Nose
- [ ] Hives
- [ ] Itchy Eyes or Nose
- [ ] Nasal allergies/ Hay Fever
- [ ] Nasal Congestion

Constitutional

- [ ] Loss of APpetite
- [ ] Sweats
- [ ] Fever
- [ ] Fatigue
- [ ] Weight Gain
- [ ] Weight Loss

Gastrointestinal

- [ ] GERD/Heartburn/Indigestion
- [ ] Black or Bloody Stools: Diarrhea
- [ ] Nausea/Vomiting
- [ ] Jaundice
- [ ] Abdominal Pain

Respiratory

- [ ] Cough
- [ ] Asthma
- [ ] Wheezing
- [ ] Poor ExerciseTolerance

Genitourinary

- [ ] Bed Wetting
- [ ] Frequent Urination
- [ ] Difficulty Urinating
- [ ] Blood in Urine
- [ ] Erectile Dysfunction

Eyes

- [ ] Blurry Vision
- [ ] Double Vision
- [ ] Vision Loss

Cardiac

☐ Palpitations ☐ Chest Pain ☐ Daytime Shortness of Breath ☐ Nighttime Shortness of Breath
☐ Ankle Swelling

Skin

☐ Unusual Moles ☐ Rash ☐ Dryness

Endocrine

☐ Heat Intolerance ☐ Excessive Thrist ☐ Constipation ☐ Cold Intolerance ☐ Cold Hands/Feet ☐ Decreased Libido

Musculoskeletal

☐ Stiff Sore Joints ☐ Muscle Pain
☐ Red or Swollen Joints ☐ Tempromandibular Joint (TMJ) Pain/Jaw Discomfort

Ears/Nose/Throat/Mouth

☐ HEaring Loss ☐ Sore Throat ☐ Sinus Congestion ☐ Hoarseness

Neurologic

☐ Weakness ☐ Seizures ☐ Involuntary Tongue Biting ☐ Passing Out ☐ Dizziness
☐ Headaches ☐ Numbness ☐ Restless Leg Syndrome

Psych

☐ Excessive Stress ☐ Memory Loss ☐ Difficulty with Focus ☐ Trouble Concentrating ☐ Hallucinations
☐ Nervousness or Anxiety ☐ Depressed Mood

List your Physician/Specialist Name & Phone #:

_____

_____

_____

_____

_____

Have you ever had any serious illnesses or operations:

_____

_____

_____

_____

_____

Have you ever had your tonsils and/or adenoids surgically removed? ◯ Yes ◯ No

Are you currently taking any Medications, Supplements and/or Vitamins? Please list & describe:

_____

_____

_____

_____

_____

Women Only - Are you:

☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

Previous Dentist Name and Phone #:

Date of most recent Dental Exam & X-rays:

I routinely see my Dentist every:

◯ 3 mo. ◯ 4 mo. ◯ 6 mo. ◯ 12 mo. ◯ Not routinely

What is your immediate concern?

Dental History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had abnormal bleeding with teeth removed

If any of the checked boxes need further explanation, please describe:

Social History

Caffeine ◯ Yes ◯ No

# of cups of coffee per day _____

# of cans of glasses of soda per day _____

# of energy drinks per day _____

# of cups of tea per day _____

# of servings of chocolate per week _____

Alcohol ◯ Yes ◯ No

# of drinks per day _____

# of drinks per week _____

# of drinks per month _____

Tobacco ◯ Yes ◯ No

 # packs per day _____

# of years _____

Recreational Drugs (such as marijuana, cocaine, etc) ◯ Yes ◯ No

If yes, which ones

_____

_____

Housing Information:

◯ Parents/Relative ◯ Own ◯ Rent ◯ Other

Marital Status

◯ Married ◯ Single ◯ Divorced ◯ Widowed

Children ◯ Yes ◯ No

If yes, How many? _____

Pets ◯ Yes ◯ No

If yes, How many? and What type?

_____

_____

Do you have children or pets that sleep in your bedroom? ◯ Yes ◯ No

Family History

Do you have family history of any of the following medical illnesses? (Check if "yes" to all that apply)

☐ High Blood Pressure/Hypertenstion	☐ Diabetes	☐ Chronic Insomina	☐ Heart Disease
☐ Overweight/obesity	☐ Restless legs syndrome	☐ Stroke	☐ Snoring
☐ Multiple Sclerosis	☐ Congestive Heart Failure	☐ Sleep Apnea	☐ Sleep Walking
☐ Depression	☐ Anxiety		

Consent for Services and Financial Policy

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

Drugs and medications:

I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.

Changes in treatment plan:

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. These changes will be discussed with me and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/medical emergency.
I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

As a condition of treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment begins and paid prior to its completion. If you choose to discontinue care before your treatment is complete, your refund will be determined upon review of your case. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment. Dolce Dental will help prepare the patient's insurance forms and assist in making collections from insurance companies, but we cannot guarantee coverage. While we can give an approximate estimate of coverage, it is not a guarantee. As the patient, you are responsible for any payments the insurance does not cover. Your co-payment and deductible is expected at the time of service. You will be billed for any remaining balance that your insurance company does not pay.*

Monthly payment plans are available with no interest through Care Credit for those who qualify. Dolce Dental accepts most major credit cards, and patients who pay with check or cash prior to completion of treatments costing more than $500 will receive a 5% courtesy discount.

I understand that any fee estimates for proposed dental treatments are valid only for a period of six months from the date of the estimate. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2000 or more, a 10% deposit is required to secure your initial treatment appointment.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* Dolce Dental will work with your insurance carrier to maximize your benefit and directly bill them for your treatment, however, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

☐ ***By checking this box, I understand the above information and agree with its contents.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization, and that I have access to and may have a paper copy of the Notice of Privacy Practices at any time.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ **By checking this box, I understand the above information and agree with its contents.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Patient Appointment Policy

☐ ***I understand that missed appointments are very costly for the practice and that the doctor and other staff members are paid to be here just for me at that scheduled time. Because of these costs, I agree to give the office at least 48 hours notice (2 business days) of any need to change or cancel regular appointments, and 3 business days notice for longer procedures such as implant surgery, crown, bridge or denture work.**

☐ ***I understand that if I miss an appointment and fail to give proper notice, I may be charged to cover some of the expense: $50 for regular appointments and $90 for longer procedures. I also understand that as a parent (guardian) I agree to be responsible for my child's (ward's) appointments.**

☐ ***I understand that although it is common practice for Dolce Dental's staff to make multiple attempts to remind me of upcoming appointments via appointment cards, emails, texts, and phone messages, it is ultimately my responsibility to remember and make my appointments.**

Name of Patient, Parent or Guardian completing this form: *

_____

_____

_____

Response Date: _____