OFFICE USE ONLY
PROVIDER INITIAL: DATE:

John T. Veale D.M.D., M.P.H.
Peter G. Veale D.M.D.

Name _____ **Date of Birth** _____ **SS #** _____ **Date** _____

Primary Care Physician's Name _____ Physician's Phone # _____

Are you currently taking any medications □ **Y** □ **N** : **If yes please list** (*note: if you have a written list we can take a photo copy)*

_____

Has a physician advised you an antibiotic premedication is needed for dental treatment? □ **Y** □ **N** If yes which RX? _____

Have you had a serious illness or operation? □ **Y** □ **N** If yes, please describe _____

Are you currently under physicians care? □ **Y** □ **N** If yes, please describe _____

Best Contact Phone # _____ **Occupation:** _____

Emergency Contact: Name _____ Relation _____ Phone _____

Medical History and Information (***Please indicate if you have had any of the following***)

Do you smoke / use tobacco? □ **Y** □ **N**
Are you taking birth control? □ **Y** □ **N**
Are you pregnant? □ **Y** □ **N**
Are you nursing? □ **Y** □ **N**

ALLERGIES

□ Aspirin
□ Barbiturates (Sleeping Pills)
□ Codeine
□ Dental Anesthetics
□ Erythromycin
□ Iodine
□ Latex
□ Metals
□ Penicillin
□ Seasonal Allergies
□ Sulfa
□ Tetracycline
□ Other Allergies _____

CONDITIONS

□ Abnormal Bleeding
□ Alcohol Abuse
□ Anemia
□ Angina Pectoris
□ Arthritis
□ **Artificial Heart Valve**
□ Asthma
□ Back Problems
□ Blood Disease
□ Blood Transfusion
□ Cancer
□ Chemotherapy
□ Circulatory Problems
□ Colitis
□ Congenital Heart Defect
□ Cortisone Treatments
□ Cough Persistent or Bloody
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Facial Surgery
□ Fainting or Dizzy
□ Fever Blisters
□ Glaucoma
□ Headaches
□ **Heart Attack**
□ **Heart Murmur**
□ **Heart Problems**
□ **Heart Surgery**
□ Hemophilia
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Herpes
□ High Blood Pressure
□ HIV / Aids
□ Jaundice
□ Jaw Pain
□ **Joint Replacement**
□ Kidney Problems
□ Liver Disease
□ Low Blood Pressure
□ **Mitral Valve**
□ Nervous Problems
□ Pace Maker
□ Psychiatric Care
□ Radiation Treatment
□ Respiratory Disease
□ **Rheumatic Fever**
□ **Scarlet Fever**
□ Seizures
□ Sexually Transmitted Diseas
□ Shingles
□ Shortness of Breath
□ Sickle Cell Disease
□ Sinus Problems
□ Skin Rash
□ Special Diet
□ Stroke
□ Swollen Feet/Ankles
□ Swollen Neck Glands
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumor/Growth on Head/Ne
□ Ulcers
□ Other Conditions? _____

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental service agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesi and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Signature _____ **PrintName** _____ **Date** _____

John T. Veale D.M.D., M.P.H.
Peter G. Veale D.M.D.
448 Turnpike St. S. Easton, MA 02375
45 Slocum Rd. Dartmouth, MA 02747

Patient Information

Name: (*First*) _____ (*Last*) _____ (*Middle Initial*) _____ (*Preferred Name*) _____

Address: (*Street*) _____

(*City*) _____ (*State*) _____ (*Zip*) _____

Date of Birth _____ □ Male □ Female

Phone: Home (____) _____ □ □ Single □ Married □ Divorced □ Widowed

Work (____) _____ □ Social Security # _____

Cell (____) _____ □ Email: _____

Please check primary contact phone number.

How did you hear about us? □ Yellow Pages □ Internet □ Walk in □ Insurance
□ Patient Referral _____ □ Other _____

Are you currently a full time college student? □ Y □ N * If yes, name of college _____

Primary Dental Insurance

Subscriber Name _____ SS # / Subscriber # _____ D.O.B _____

Insurance Co. _____ Insurance Co. Phone # _____

Employer _____ Relation to Patient _____

Secondary Dental Insurance

Subscriber Name _____ Subscriber ID # _____ D.O.B _____

Insurance Co. _____ Insurance Co. Phone # _____

Employer _____ Relation to Patient _____

Dental History (*Please indicate if you have had any of the following*)

Reason for today's visit _____ Date of last dental visit _____

□ Bad breath
□ Bleeding gums
□ Blisters on lips or mouth
□ Burning sensation on tongue
□ Chew on one side of mouth
□ Cigarette, pipe, or cigar smoking
□ Clicking or popping jaw
□ Dry mouth
□ Fingernail biting
□ Food collection
□ Grinding teeth
□ Gums swollen / tender
□ Jaw pain or tiredness
□ Lip or cheek biting
□ Loose teeth/fillings
□ Mouth breathing
□ Orthodontic treatment
□ Pain around ear
□ Periodontal treatment
□ Sensitivity cold or hot
□ Sensitivity sweets or biting
□ Sores or growths in mouth
□ How often do you floss _____
□ How often do you brush _____

The information on this page is correct to the best of my knowledge.

Signature _____ **Print** _____ **Date** _____

If Patient is a child: *Parent or Guardian Signature* _____ Print Name _____ Date _____

JOHN T. VEALE, DMD, MPH
PETER G. VEALE, DMD

448 TURNPIKE STREET, SUITE 1-5
SOUTH EASTON, MA 02375

45 SLOCUM ROAD
DARTMOUTH, MA 02747

Patient HIPAA Consent Form

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care operation.

We want you to know that we respect the privacy of your medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but not limited to laboratories, pharmacies and other medical offices. As such, we may need to discuss PHI for purposes of treatment, payment and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. This refusal must be in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of you PHI. This refusal must be in writing. However, you may not revoke actions that have already been taken, which relied on this or a previously signed consent.

You may receive a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our office if you have any objections to this consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Date _____

Print Patient Name _____

Signature _____
Relationship to Patient _____