George W. Pirie, D.M.D., Ltd.
Practice Limited to Periodontics

REGISTRATION

Name _____ Date of Birth _____ Today's Date _____

If Child,
Parent's Name _____

DENTAL INSURANCE 1st COVERAGE

Address _____ Employee Name _____

_____ Employee Birthdate _____ SS# _____

City _____ State _____ Zip _____ Employer Name _____

Telephone Home _____ Insurance Co. Name _____

Telephone Business _____ Insurance Co. Address _____

Cell _____ ID # _____

Marital Status _____ Telephone of Ins. Co. _____

Patient Employed By _____ Group Policy No. _____ Union Local _____

Present Position _____

DENTAL INSURANCE 2nd COVERAGE

Spouse Employed By _____ Employee Name _____

Present Position _____ Employee Birthdate _____ SS# _____

Members of your family who are patients here

Employer Name _____

_____ Insurance Co. Name _____

Whom may we thank for this referral?

Insurance Co.Address _____

_____ ID # _____ Group # _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another doctor and/or my insurance company. I understand that I am responsible for all costs of dental treatment. I attest to the accuracy of the information on this page.

Patient's or Guardian's signature _____ Date _____

OFFICE POLICY:

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement for appointments and fees. Once you have made an appointment, remember that this time is reserved expressly for you; therefore AT LEASET **48** HOURS NOTICE must be given if cancellation is ABSOLUTELY NECESSARY, otherwise the usual fee CHARGE WILL BE MADE TO YOUR ACCOUNT.

Generally, we prefer not to accept assignment of insurance benefits and will discuss fees and method of payment with you. You will be given a statement of charges on the day services are rendered. Payment is due within 30 days following the date of treatment unless other arrangements are made in advance.

My signature indicates that I participated in gathering the above information and that I have been advised of and agree to the general office policies regarding appointments and payment.

Patient's or Guardian's signature _____ Date _____

Name _____ Date of Birth _____ Today's Date _____

Your honest and complete answers to the following questions are important to your own health and safety. Please circle or fill in whichever applies. Your answers will be used in this office only and will be kept confidential.

1. Physician's name _____ Telephone _____

   Address _____

2. Have you ever had a serious illness or operation? ❑Yes ❑ No If Yes, explain:

   _____

   _____

3. Have you ever needed a blood transfusion? ❑Yes ❑ No Date _____
4. Are you presently under a physician's care? ❑Yes ❑No For what reason? _____

   _____

5. When was your last complete physical exam? _____
6. What medication have you taken today? _____

   Do you take a daily aspirin, vitamin E supplement, Coumadin or Plavix? ❑Yes ❑No Which? _____

   List other medications you take regularly: _____

7. Please list medications or substances that you are allergic to: _____

8. Do you have asthma? ..... Yes ❑ No ❑
   Do you have emphysema? ..... Yes ❑ No ❑
   Do you have or have you had T.B.? ..... Yes ❑ No ❑
9. Do you have or have you been told you might have heart disease? ..... Yes ❑ No ❑
10. Have you had rheumatic fever? ..... Yes ❑ No ❑
    heart Murmur? ..... Yes ❑ No ❑
11. Do you have a pacemaker or an artificial heart valve implant? ..... Yes ❑ No ❑
12. Do you have any artificial joints/prosthesis? ..... Yes ❑ No ❑
13. Does your physician suggest medication prior to dental treatment? ..... Yes ❑ No ❑
14. Do you have inflammatory diseases, arthritis or rheumatism? ..... Yes ❑ No ❑
15. Have you had surgery, radiation or chemo treatment for a tumor, growth or other condition? ..... Yes ❑ No ❑
16. Do you have high or low blood pressure? ..... Yes ❑ No ❑
17. Do you have any blood disorders, anemia, leukemia, etc? ..... Yes ❑ No ❑
18. Have you ever bled excessively after being cut? ..... Yes ❑ No ❑
19. Do you have any stomach, liver or kidney problems? ..... Yes ❑ No ❑
20. Have you ever had hepatitis? ..... Yes ❑ No ❑
21. Are you diabetic? ..... Yes ❑ No ❑
22. Have you ever had a nervous condition, mental breakdown, psychotherapy? ..... Yes ❑ No ❑
23. Do you have epilepsy or seizure disorders? ..... Yes ❑ No ❑
24. Do you have difficulty hearing? ..... Yes ❑ No ❑
25. Do you have or have you had venereal disease? ..... Yes ❑ No ❑
26. Do you have AIDS or are you HIV positive? ..... Yes ❑ No ❑
27. Do you smoke? ..... Yes ❑ No ❑
    Do you consume alcoholic beverages? ..... Yes ❑ No ❑
28. Are you or have you been treated for alcohol abuse and/or chemical dependency? ..... Yes ❑ No ❑
29. Are you pregnant or suspect you may be? ..... Yes ❑ No ❑
30. Do you have any disease, condition or problem not listed? ..... Yes ❑ No ❑
    Please explain: _____
31. Do you take any medication for osteoporosis? ..... Yes ❑ No ❑
32. Do you take any herbal supplements? ..... Yes ❑ No ❑

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE AND THAT I PARTICIPATED IN GATHERING THE ABOVE INFORMATION.

Patient's or Guardian's signature _____

ANEST.	**MEDICAL HISTORY**	MED. ALERT

Patient's Name _____ Date of Birth _____

1. Purpose of initial visit: _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Dentist's name _____

   Address _____
6. When was your last professional cleaning? _____

   PLEASE CHECK APPROPRIATE ANSWER:
7. Have you lost any teeth? ..... Yes ❑ No ❑

   Why? _____
8. Have they been replaced? ..... Yes ❑ No ❑
9. How have they been replaced? ❑Fixed bridge ❑Removeable bridge ❑Denture
10. If you are not happy with the replacement please explain: _____

    _____
11. Do you clench or grind your teeth? ..... Yes ❑ No ❑
12. Does your jaw click or pop? ..... Yes ❑ No ❑
13. Have you had any pain/soreness in facial muscles or around ears? ..... Yes ❑ No ❑
14. Do you have frequent headaches, neck aches or shoulder aches? ..... Yes ❑ No ❑
15. Does food get caught between your teeth? ..... Yes ❑ No ❑
16. Are any of your teeth sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Pressure
17. Do your gums bleed or hurt? ..... Yes ❑ No ❑
18. How often do you brush your teeth? _____ When? _____
19. How often do you use dental floss? _____
20. Are any of your teeth loose, tipped, or shifted? ..... Yes ❑ No ❑
21. Do you feel your breath is offensive at times? ..... Yes ❑ No ❑
22. Have you ever had gum treatment or gum surgery? ..... Yes ❑ No ❑

    What? _____ When? _____

    Where? _____
23. How do you feel about your teeth in general? _____
24. Have you ever had any problems or complications with previous dental treatment or had any unpleasant experiences or anything about dentistry that you strongly dislike? Do you have questions or concerns? _____

    _____

    _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's or Guardian's signature: _____ Date _____

ANEST.

DENTAL HISTORY

MED. ALERT

GEORGE W. PIRIE, D.M.D., LTD.
LIMITED TO PERIODONTICS
77 TOLL GATE ROAD
WARWICK, RI 02886
(401) 737-3663

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and education tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative cost.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

As a courtesy to you, we will process all your insurance claims. In order for our office to file your insurance claim, you must bring a **dental insurance card** to your appointment. Some insurance companies send payment directly to the patient. It is the patient's responsibility to forward that check to our office.

Payment is due at the time service is provided unless other financial arrangements are made prior to your appointment. Our office accepts Cash, Personal Checks, MasterCard, Visa, and Discover Card. Outside financing is available through CareCredit upon request and approval.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). In the event of a returned check, a fee of $25.00 will be imposed. Additionally, our office will charge you for broken appointments and appointments cancelled without 48 hour (two business days) notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____
Print Name

_____
Signature

_____
Date

George W. Pirie D.M.D. Ltd

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Karen Verrier

Telephone: 401-737-3663 Fax: 401-738-6085

E-mail: _____

Address: 77 Tollgate Road, Warwick, R.I.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.