Generations Dental Center

Pediatric and Adult Dentistry

Gentle, quality care for the entire family

75 Herrick St., Suite 212
Beverly, MA 01915
(978) 921-7575
www.generationsdentalcenter.com

Thank you for visiting Generations Dental Center. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Child Information (if patient is a child)

Name____ ___Male ___Female
LAST FIRST MIDDLE INITIAL

Height_____ Weight_____ Social Security #____________________ Birth Date_______________

Adult Patient or Parent Information

Name____
LAST FIRST MIDDLE INITIAL NICKNAME

Address____
STREET CITY STATE ZIP

Employer________________________________ Driver License___________________________

Birth Date_______________________________ ___Married ___Single ___Other

Height_______________ Weight____________ ___Male ___Female

Phone: Home (_____) ____________________ Social Security #________________________

Work (_____) ____________________ Email__________________________________

Cell (_____) ____________________

Emergency Contact ________________________ Phone (_____) ________________________

Insurance

Primary Dental Carrier

Subscriber Name______________________ Social Security #_______________ DOB___________

____________________________ ____________________________ ___________________
Employer Insurance Co. Insurance Co. Phone #

Group #______________________ ID#___________________ Relation to patient___________

Secondary Dental Carrier

Subscriber Name______________________ Social Security #______________ DOB____________

____________________________ ____________________________ ___________________
Employer Insurance Co. Insurance Co. Phone #

Group #______________________ ID#___________________ Relation to patient___________

Health Information

Have you ever had any complications following dental treatment? __ Y __ N
If yes, please explain____
Have you had a serious illness or operation? ____Y ____N
If yes, please describe____
Physician's Name______________________________ Physician's Phone (______) ________________
Are you currently under physician care? ____Y ____N
If yes, please describe____
Have you EVER taken any medications for osteoporosis? (e.g. Fosomax) __ Y __ N
If yes, what medications have you taken? ______________________________________
Please list any medications you are currently taking:____________________________

____

Have you ever had any of the following? Please check those that apply:

Conditions

___ Abnormal Bleeding
___ Alcohol Abuse
___ Allergies
___ Anemia
___ Angina Pectoris
___ Arthritis
___ **Artificial Heart Valve**
___ Asthma
___ Blood Transfusion
___ Cancer
___ **Chemotherapy**
___ Colitis
___ **Congenital Heart Defect**
___ Diabetes
___ Difficulty Breathing
___ Drug Abuse
___ Emphysema
___ Epilepsy
___ Facial Surgery
___ Fainting Spells
___ Fever Blisters
___ Frequent Headaches
___ Glaucoma
___ HIV or Aids
___ **Heart Attack**
___ Low Blood Pressure
___ **Recreational Drugs**
___ Sinus Problems
___ **Joint Replacement**
___ **Heart Murmur**
___ Heart Surgery
___ Hemophilia
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ **High Blood Pressure**
___ **Kidney Problems**
___ **Liver Disease**
___ Mitral Valve Prolapse
___ Pace Maker
___ Psychiatric Problems
___ Depression
___ **Anxiety**
___ Radiation Therapy
___ Rheumatic Fever
___ Seizures
___ Sexually Transmitted Diseases
___ Shingles
___ Sickle Cell Disease
___ Stroke
___ Thyroid Problems
___ Tuberculosis
___ Ulcers
___ **Other**______________

Allergies

___ Aspirin
___ Codeine
___ Dental Anesthetics
___ Latex
___ Metals
___ **Penicillin**
___ Erythromycin
___ Sulfa
___ Tetracycline
___ **Other**________________

__ **Y** __ **N** Do you Smoke or use Tobacco?

If Female
Y N
___ ___ Are you taking Birth Control Pills?
___ ___ Are you pregnant? If yes, # of weeks_____
___ ___ Are you nursing

The information listed above is correct to the best of my knowledge. (Sign & Date)

_________________________________ ______________ ________________
Patient Signature (Parent or Guardian) Date Relationship to Patient

Reviewed by Doctor ______________________________ Date ______________________________

Significant Findings ____

____

Office Policy and Consent for Services

We are very happy to have you as a new patient in our office. At Generations Dental Center, we take a lot of pride in meeting or exceeding our patients' needs. This keeps us very busy, so we do require each patient to read and understand our office policy.

We require that each patient maintain current information in their chart. Please notify our office if there has been any change in address, insurance, and medical information.

Due to the high number of patients requiring dental care, waiting times for appointments can be long. Because of this, we enforce a missed appointment policy to ensure that other patients receive care in a timely manner. Missed appointments and appointments cancelled without 24-hour notice are subject to a cancellation fee of $50 per half-hour of the scheduled appointment time.

If a patient is more than 15 minutes late for their appointment, the appointment may be canceled.

As a condition of your treatment by this office, financial arrangements must be made in advance. Payment for services is due at the time services are rendered unless payment arrangements have been approved by our staff.

Patients with Dental Insurance

We are working for you and not the insurance company. We have no control over how well they pay or how they treat you. There are thousands of combinations of insurance plans and coverages depending on what your employer purchased for you. **WE DO NOT BASE OUR CLINICAL EXAM OR YOUR TREATMENT PLAN ON WHAT YOUR INSURANCE COVERS OR DOESN'T COVER.**

If you have insurance, we are willing to help you in processing your claim in order to receive maximum allowable benefits. Patients should know their deductibles as well as percentage of coverage of individual procedures. We will file your pre-treatment estimates, at your request, as a service to you. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. While the filling of insurance claims is a courtesy that we may extent to our patients, all charges are ultimately your responsibility. If any payment from an insurance company becomes 30 days past due, then you will be billed for the entire balance.

Payment

We accept cash, Mastercard, Visa, or CareCredit. CareCredit is a convenient, interest free or low interest, monthly payment plan that allows you to spread your balance over several months. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. We realize that temporary financial problems may affect timely payment of your account. If a problem arises we encourange you to contact us promptly for assistance in the management of your account.

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I give my permission for this office to take video and photographs to be used for diagnostic, insurance, practice development and advertising purposes. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____________________ Patient Signature (Parent or Guardian)	__________ Date	____________ Relationship to Patient

How did you hear about us? __Mail __Google __Yahoo __Walk in __Insurance

__Referral______________________ __Other_________________________

Acknowledgement of Receipt of Notice of Privacy Practices

We must provide this Notice to each patient no later than the date of our first service delivery to the patient. We must also have the Notice available at the office for patients to request to take with them. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice.

We must make a good faith effort to obtain a written acknowledgement of receipt of this Notice from each individual with whom we have a direct treatment relationship and to whom we provide this Notice, except in emergency situations. If we do not obtain the acknowledgement, we must document our efforts and the reason we did not obtain the acknowledgement. The last page of the Notice is a written acknowledgement that each patient should sign. We should keep the acknowledgement in the patient's dental record.

I, ____, acknowledge that I have received a Notice of Privacy Practice from Generations Dental Center.

Disclosure

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Generations Dental Center in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Generations Dental Center in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send and e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

_______________________________	______________	__________________
Patient Signature (Parent or Guardian)	Date	Relationship to Patient