Adult Pre-Clinical History

Today's Date: _____ /_____ / _____

The benefits of a healthy smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete these forms so that we can provide the best care possible for you. Thank you!

ABOUT YOU (Please Print Legibly)

Name: Last: _____MI:_____First:_____ ☐Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ **Cell Phone:** _____ Wk. Phone: _____ext:____

Birth Date: _____/_____/_____ Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number: _____-_____-_____ Employer: _____

***E-mail Address:** _____

(Used for Communication ONLY. We confirm patient reservations via email and texting.)

Who Can We Thank For Referring You To Our Office: _____

Preferred Pharmacy: _____Location:_____PH#_____

Emergency Contact: Name: _____PH#:_____

Responsible Party/Billing Information (*If Same as Above, Please Indicate Here*: ☐SELF)

Name: Last: _____MI: _____First: _____ Relation to Pt: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ /_____ /_____

I (Patient Name): _____hereby authorize *Modern Dentistry of New England* to administer any treatment and to perform such as X-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. *No guarantees* can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results**. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that I am responsible for *any* costs that my insurance medical or dental does not cover.** My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient or Guardian Signature: _____Date:_____/_____/_____

INSURANCE INFORMATION (Please give the front desk your cards so that we may make a copy)

PRIMARY DENTAL INSURANCE

Policy Subscriber Name: _____

Policy Subscriber Date of Birth: _____/_____/_____

Dental Ins. Co. Name:_____

Policy ID# or SS#:_____

Relationship to Subscriber: ☐Self ☐Spouse ☐ Parent ☐ Other

Employer Name:_____

Group#:_____

SECONDARY DENTAL INSURANCE (If applicable)

Policy Subscriber Name: _____

Policy Subscriber Date of Birth: _____/_____/_____

Dental Ins. Co. Name:_____

Policy ID# or SS#:_____

Relationship to Subscriber: ☐Self ☐Spouse ☐ Parent ☐ Other

Employer Name:_____

Group#:_____

MEDICAL INSURANCE COVERAGE

Policy Subscriber Name: _____

Policy Subscriber Date of Birth: _____/_____/_____

Medical Insurance Company Name:_____

Policy ID# or SS#:_____

Relationship to Subscriber: ☐Self ☐Spouse ☐ Parent ☐ Other

Employer:_____

Group#:_____

Is this an insurance Policy from your Employer Past or Present? ☐ YES ☐ NO

Is this a Medicare Policy or supplement? ☐ YES ☐ NO

Did you purchase this insurance through *Affordable Care Act?* (ObamaCare) ☐ YES ☐ NO

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City:
State:
Zip:
Occupation:
~~Height~~: NA
~~Weight~~: NA
Date of Birth:
Sex: M F
SS# or Patient ID:
Emergency Contact:
Relationship:
Home Phone: *Include area code* ( )
Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? (*Check one:*) DAILY☐ / WEEKLY ☐ / OCCASIONALLY ☐

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

MEDICAL HISTORY

Have you ever had an adverse reaction to any of the following? (Please check if allergic)

- ○ Local anesthetics_____
- ○ Penicillin / Amoxicillin
- ○ Erythromycin
- ○ Sulfa drugs
- ○ Aspirin
- ○ Codeine
- ○ Barbiturates, sedatives, etc.
- ○ Latex
- ○ Other_____

Have you ever had *or* do you have any of the following conditions? (Please check all that apply)

- ○ Allergies(Seasonal)
- ○ Arthritis/Gout
- ○ Artificial Joint*
- ○ Asthma
- ○ Bleeding Problems/Anemia
- ○ Blood Transfusion
- ○ Blood Disease
- ○ Bruise Easily
- ○ Cancer
- ○ Cold Sores
- ○ Congenital Heart Problems*
- ○ Currently Pregnant ___/___/____
- ○ Diabetes
- ○ Dizziness/Fainting
- ○ Drug / Alcohol Addiction
- ○ Eating Disorder
- ○ Emphysema
- ○ Epilepsy/Seizures
- ○ Fever Blisters
- ○ Frequent Thirst
- ○ Frequent Urination
- ○ Glaucoma
- ○ Gerd / Acid Reflux
- ○ HIV-AIDS-ARC
- ○ Heart Attack*
- ○ Stroke
- ○ Heart Murmur*
- ○ Heart Trouble/Surgery*
- ○ Artificial Heart Valve/Pacemaker*
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Hepatitis C
- ○ Herpes
- ○ High Blood Pressure
- ○ Hypoglycemia
- ○ Hyperglycemia
- ○ TMJ/Jaw Pain
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Psychiatric Care
- ○ Rheumatic Fever
- ○ Sinus Problems
- ○ Sleep Apnea
- ○ Hyper Thyroid Condition
- ○ Hypo Thyroid Condition
- ○ Tuberculosis
- ○ Tumors/Growths
- ○ Ulcers/ G.I Problems
- ○ Tobacco use
- ○ Radiation or Chemo Therapy
- ○ Other_____

***(For women)* Are your currently pregnant? ☐*Yes* ☐*No* If yes, how many months? _____ Are you nursing: ☐*Yes* ☐No**

***Do you need to be pre-medicated for any dental treatments because of Pins, Screws, Plates, Artificial Joints or Heart issues?** ☐Yes ☐No If Yes, please indicate reason: _____RX given: _____

Name of personal physician: _____

Address: _____ Phone number: _____

Approximate date of last visit: _____ Current health condition: ☐Excellent ☐Good ☐Fair ☐Poor

Have you had any serious health problems in the last five years? ☐Yes ☐No If yes, please explain: _____

_____

Please List Prescription medications and Vitamin/Herbal Supplements & Dosages:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor or staff at the next appointment without fail.

Patient or Guardian Signature: _____Date:_____/_____/_____

Late, Cancellation and Missed Appointment Contract

for Modern Dentistry of New England

We certainly understand that occasionally circumstances arise that prevent patients from keeping appointments. **However, our office requires a 48 hour notice for proper cancellation or rescheduling of appointments. A missed, no show or appointment cancellation without a 48 hour notice will be charged a $25 fee. Saturday appointments have a $50.00 fee. This fee must be paid before any future appointments will be given.**

We view our appointment times as a *commitment* that we will be here to serve you, and you will be present for that appointment. Without a 48 hour notice, we cannot give that appointment opportunity to someone else who needs it. Also, we request this courtesy because it allows us to see our patients promptly and helps us provide more affordable dental care for all of our patients.

As a courtesy, we send out hygiene reminder cards, email reminders, text messages and/or provide a phone call prior to the appointment you have scheduled. ***Again, these reminders are a courtesy***. If for some reason you do not receive these reminders, your appointment is still ***your responsibility*** and the **charges will still apply if the appointment is not kept or cancelled properly.**

Thank you, in advance, for your cooperation. Having understanding patients enables us to better serve the needs of our patients.

*****We require confirmation of appointments. We make every effort to contact you via Email, text or phone. Please do us the courtesy to respond to our attempts.*****

For any appointment made that is over 90 minutes long, our office requires an appointment reservation deposit of 50% of your estimated copay. That will be applied toward payment of your dental treatment. The Balance is due upon your treatment appointment date.

I, _____

have read and understand the above Statement.

Patient/Guardian Signature: _____ Date:__/_____/____

Modern Dentistry of New England Financial Policy /Agreement

We are committed to providing you with the highest quality of dental care utilizing only the best materials and technology available. In our efforts to do so, we have formulated the following financial policy. We value our patients and have worked hard to provide several options to meet your needs***. Please read this policy carefully!***

Many patients have a commonly held misconception that medical and dental benefit policies that their employer, or they individually, have purchased will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

Financial responsibility for all services received at this office regardless of insurance coverage is yours alone.

Modern Dentistry of New England is happy to partner with our patients who are covered by dental/medical insurance, by billing the insurance for you. However, it is **your responsibility** to inform us when your policy changes so we can bill the correct carrier. We ask that **YOU read your policy thoroughly** so that you are fully aware of the benefits provided and the limitations imposed. Please call your insurance company if you have any questions concerning your plan. Please understand that our responsibility is to provide you with **Superior Dental Care** and the treatment that best meets your needs, not on what your dental insurance policy covers.
It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. Estimated patient portions are due at time of service. We do our best to **estimate** your patient portion prior to your appointment. These estimates are based on the outline given by your insurance plan. **Please note that these are estimates only. As stated by all insurances companies, there is *not a guarantee of payment until the actual claim is processed.* Due to policy differences and clauses you may owe more than we *estimate*. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.** If your insurance company pays more than the estimate we will issue a prompt refund via check.

Medical Insurance Company Billing,** Will be discussed on an ***individual basis with each patient, and a separate financial responsibility contract will need to be signed.

*Outstanding insurance claims over 90 days, become the patient's responsibility. All incurred charges are ultimately the responsibility of the patient.
We are unable to carry "patient" balances over 90 days in the office. . Therefore, all overdue balances of 90 days or more are sent out of the office for collection. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care
PAYMENT OPTIONS: We are pleased to offer 3 payment options for our patients:
1. We gladly accept Cash, Check (25.00 return check fee) Visa, MasterCard and American Express for your convenience.
2. Care Credit & Lending Point: Are special No interest financing options provided by our Office.
3. *Limited in house financing on* certain types of treatment: ½ at start of treatment with balance due upon completion.

I HAVE READ THE ABOVE FINANCIAL RESONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO Dr.Gabr Modern Dentistry of New England FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient/Guardian Name: _____ Date:_____/_____/_____

Patient/Guardian Signature: _____ Witness:_____

SIGNATURE RELEASE STATEMENT/ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE COMPANY CLAIMS**
2. **ENSURE PAYMENT FOR SERVICES PROVIDED**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**
4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS INCLUDING, LABORATORIES,WHEN NECESSARY, FOR YOUR TREATMENT**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as labs that need my information to make a diagnosis, or fabricate an appliance necessary for my treatment.

I assign all Medical / Dental and Surgical benefits, including major medical benefits to which I am entitled, to Sherif Gabr D.M.D. Modern Dentistry of New England. This Assignment will remain in effect until revoked by me in writing. A photocopy if this assignment is to be considered as valid as the original.

Patient Signature:_____

Patient Full Name (Printed):_____

Parent Signature if Patient is a minor:_____

Witness:_____

Date Signed: _____/_____/_____

Notice of Privacy Practices

Sherif Gabr D.D.S – DBA Modern Dentistry of New England

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose such information.

Without specific authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Unless you request otherwise, we may use or disclose your health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and leaving messages at your home or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights:

• The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree, we must abide by it.

• The right to request to receive confidential communications of protected health information by alternative means or at alternative locations.

• The right to access, inspect and copy your protected health information.

• The right to request an amendment to your protected health information.

• The right to receive an accounting of disclosures of protected health information, outside of treatment, payment and health care operations.

• The right to obtain a paper copy of this agreement upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. You have the right to file a formal complaint with us or with the Department of health & Human Services, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint, please contact: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue S.W., Washington D.C. 20201, (877) 696-6775

For more information about our Privacy Practices, please contact: Modern Dentistry of New England 225 N. Main St. Bristol CT 06010 (860)582-4485

This page is for your records.