DENTAL ASSOCIATES OF CAPE COD PATIENT REGISTRATION

Today's Date:__________________ **E-Mail:**________________

Patients Name______________________________Home Phone_____________Cell Phone________________
last first m.i.
Patients Address____
street city state zip code
Mailing Address (if different) ____

So. Sec. #.__________________Driver License #_________________________Birthdate________________

Sex ____Male _____Female Marital Status_______________ Length at present address__________________

Patients employer__________________________Position_____________Length at present employer________

Employers address_____________________________Work phone____________Ext________Dept_________

Nearest relative not residing with you___________________Phone_________Relationship to patient________

If Student: ____Full time ____Part time Name of Institute________________City_______State______

In case of emergency please contact: Name______________ Phone____________ Relationship____________

Who will pay this account? (Whose name will appear on billing statement). ___Self___Spouse___Parent/Guardian
If you checked "self" Please skip next section.

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name_______________________________________Soc. Sec. #____________________
Last first m.i.
Address____Phone_______________
street city state zip code
Employer______________________Address________________________________Work Phone___________
street state
Your relationship to the above responsible party:______________________________________

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FOR PATIENTS COVERED BY DENTAL INSURANCE

Subscriber's Name____ Subscriber's Date of Birth:____________________
Last first m.i.
Soc. Sec. #_________________________ID#________________

Employer________________________Address____Phone____________________

Insurance Company Name____Phone__________________________

Address____Group #______________________

Patient relationship to subscriber ______Self ______Spouse ______Dependent

ALL INSURANCE PATIENTS – PLEASE SIGN BOTH SIGNATURE LINES BELOW

I authorize release of any information relating to this claim.
I understand that I am responsible for all costs of dental treatment.

*____
Signature (Patient or parent, if minor) Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

*____
Signature (Patient or parent, if minor) Date

***You May Refuse to Sign this Acknowledgement**

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

*** Signature: ____Date: ______________________________________**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ________________________________**E-Mail:** _____________________________________

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 our 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: Business Assistant
Telephone: 508-778-1200
Fax: 508-775-5502
Address: 262 Barnstable Rd.
Hyannis, MA 02601

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 heath 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.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ **Individual refused to sign**
- ❑ **Communications barriers prohibited obtaining the acknowledgement**
- ❑ **An emergency situation prevented us from obtaining acknowledgement**
- ❑ **Other (Please Specify)**

Dental Associates Of Cape Cod

Patient Name:_____________________________________ Date:___________

Please complete the following so that we can be sure your contact information is correct in our new software program.
In order to devote more time to our patients while they are in our office, effectively immediately, we will be using an automated system (as a courtesy) to remind of your upcoming appointment(s). This system uses e-mail, text and voice messages. Our office considers ALL appointments scheduled to be confirmed. Please be aware that the automated confirmation system does not accept changes in the schedule or cancellations. All changes must be made by calling the office directly. Our office does require 48 hours notice for any schedule changes.

Please list below your contact numbers IN the order in which you would like to be contacted.

1) ________________________ ___________________
Phone # **Type (example cell)**

2) ________________________ ___________________
Phone # **Type**

3) ________________________ ___________________
Phone # **Type**

____
E-mail address

By signing below, you give our office permission to leave basic information regarding your appointments at the above phone numbers and e-mail address.

____
Signature

____
Initial here if you DO NOT want to receive appointment reminders by "e-mail".

____
Initial here if you DO NOT want to receive appointment reminders by "Text".

PATIENT HEALTH HISTORY

Name:____ Date:_______________

How were you referred to our office?___________________________ May we thank this person?_______

In the following questions, circle or check YES or NO whichever applies. Your answers are for our records and will be considered confidential.

1. Are you in good health ?--- YES NO

2. Are you now under the care of a physician ?-- YES NO

3. The name of my physician_________________________Phone________________________

Address____

4A. Have you had any joints replaced ?____ YES NO

If so, what_________When?_______4B. Do you need to pre-medicate prior to dental procedures YES NO

5. Do you have or have you had any of the following diseases or problems? :

	YES	NO		YES	NO
Heart Attack / Stroke			Psychiatric Problems		
Cancer / Chemotherapy			Epilepsy / Seizures / Fainting spells		
Heart Murmur			Diabetes / Tuberculosis (TB)		
Previous Endocarditis			Drug / Alcohol Abuse		
Rheumatic Fever			Venereal Disease		
HIV + / AIDS			Hemophilia / Abnormal Bleeding		
Heart Surgery / Pacemaker			Ulcers / Colitis		
Shingles			Congenital Heart Defect		
Mitral Valve Prolapse			Anemia / Radiation Treatment		
Kidney Problems			Asthma / Arthritis		
Artificial Bones / Joints			Difficulty Breathing		
Artificial Valves			Hospitalized for Any Reason		
Sinus Problems			Hepatitis		
High Blood Pressure			Blood Transfusion		
Low Blood Pressure			Emphysema / Glaucoma		
Severe / Frequent Headaches			Other:		

6. Are you taking any of the following? :

	YES	NO		YES	NO
Antibiotics or sulfa drugs			Aspirin		
Anticoagulants (blood thinners) Name:			Insulin, Tolbutamide (Orinase)		
Medicine for high blood pressure			Digitalis or drugs for heart trouble		
Cortisone (steroids)			Nitroglycerin		
Tranquilizers			Oral Contraceptive (hormonal therapy)		
Antihistamines			Other-Including Vitamins and Herbs *(Please List)*		

7. Are you allergic or have you reacted adversely to? :

	YES	NO		YES	NO
Penicillin			Dental Anesthetics		
Aspirin			Codeine		
Erythromycin			Latex		
Tetracycline			*Other (list)*		

8. Do you have any disease, condition or problem not listed above that you think I should know about? If so, please explain.____ YES NO

Women

9. Are you pregnant?-- **YES NO**

10. Are you nursing?-- **YES NO**

OFFICE POLICIES

WELCOME to our office. We are happy to have you as a patient. In an attempt to maintain our fees at a reasonable level, we ask you to help us by observing the following:

BROKEN APPOINTMENTS - If you cannot keep your appointment, we ask for a 48-hour notice to avoid a possible missed appointment charge of $35.00 per ½ hour appointment. This fee is not covered by ANY insurance; therefore, you would be directly responsible.

ACCOUNTS ARE DUE AND PAYABLE ON RECEIPT OF SERVICES - Payment in full for all services is expected the day that they are rendered, unless previous arrangements have been made. Master Card, Visa and American Express are welcome.

DENTAL INSURANCE - Patients who have dental insurance are expected to pay their deductible and any co-payments in full at the time of service. Please realize that professional services are rendered to a person, not to an insurance company. Our office will attempt to get an overview of your dental coverage from your insurance company. This information will be used to calculate your expected co-payments. Please be aware that YOUR insurance company makes the final decision on what is paid on claims submitted to them by our office. Most insurance companies have a yearly maximum amount that they will pay for each individual family member. Once this maximum is reached any additional charges will be the responsibility of the patient. Your insurance company should be able to provide you with accurate information regarding available benefits for the year. You are ultimately responsible for all fees.

The undersigned hereby authorizes doctor/staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires 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 errors or omissions that I may have made in the completion of this form.

* ______________________________ ____________

Signature of Patient *Date*

* ______________________________ ____________

Signature of Dentist **Date**

^^^

Please read the following carefully and sign below.

I understand that a service charge of 1 ½% per month on the unpaid balance (18% Annual Percentage Rate) will be charged on all overdue balances, unless previous written and signed payment arrangements have been made.

I also understand that I am financially responsible for all balances incurred in this office, by my dependents or myself. I understand that if collection procedures are necessary to collect any outstanding balance, that I will be financially responsible for the entire cost of all collection procedures.

* ______________________________ ____________

Signature of Responsible Party *Date*

Authorization For Signature On File
Authorization Of Payment/Release Of Information
And Financial Responsibility

I____, understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that *Dental Associates Of Cape Cod* has accepted the insurance company's verification of coverage and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for the verified benefits, I agree to be responsible for all charges for dental services and materials, which I and/or my dependents have incurred and authorized in my and/or my dependents' treatment. I agree that any balance not paid by my insurance company within 60 (sixty) days will be my responsibility to pay. I agree to furnish the insurance company and *Dental Associates Of Cape Cod* with any additional information or paperwork requested to expedite payment of my claim. To the extent permitted under applicable law, I herby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of *Dental Associates Of Cape Cod.* I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services rendered to my dependents or me as if I had signed each benefit assignment of future claims.

I also understand that Dental Associates Of Cape Cod (Dr. Michael Seidman and Dr. Janet Butts) use composite ("tooth colored) restorations unless otherwise requested. We invite all patients to check with their insurance carrier for coverage differences, if any, between composite and amalgam (silver) restorations.

I herby authorize payment of dental benefits otherwise payable to me, directly to the office of *Dental Associates Of Cape Cod.* This "Signature On File" will be valid from this date forward. A photocopy of this document may act as an original.

________________________________ ____

Today's Date Signature Of Insured

Patient Dental History

Name:____Date:___________________

Reason for today's visit:____

Name of previous dentist:____

Date of last dental x-rays:_________________ What x-rays were taken:___________________________

Date of last dental care:____________________ Treatment received:______________________________

Circle "Y" or "N" for the following conditions:

Y	**N**	**Bad breathe / taste**	**Y**	**N**	**Loose or broken teeth**
Y	**N**	**Sensitivity to hot/cold/sweets/biting**	**Y**	**N**	**Periodontal gum / treatments**
Y	**N**	**Bleeding gums / sore gums**	**Y**	**N**	**Swelling / lumps in mouth**
Y	**N**	**Dry mouth**	**Y**	**N**	**Sores in your mouth**
Y	**N**	**Shifting of teeth / bite**	**Y**	**N**	**TMJ pain / clicking / popping in jaw**
Y	**N**	**Food Collection between teeth**	**Y**	**N**	**Do you wear dentures / partials**

Is there a history of gum/periodontal disease in your family? ____Yes _____No

Do you smoke? _________Yes __________No If yes, how much?______________________________

How often do you brush your teeth?__________Floss your teeth?__________Use mouthwash?________

Do you use manual or electric toothbrush?____

How do you feel about your smile?____

____ _________________
Patient Signature **Date**

For Office Use only:_______________________________________

Dental Associates Of Cape Cod
262 Barnstable Rd.
Hyannis, Mass. 02601
(508) 778-1200
Dr. Michael P. Seidman, D.D.S., P.C. *Dr. Janet A. Butts, D.M.D.*
Dr. Daniel C. Varallo, D.M.D., M.S.D.

Smile Analysis

Name:________________________________ Date:___________

1) Do you like the color of your teeth? ___Yes ___No

Do you wish your teeth were whiter? ___Yes ___No

2) Do you wish your teeth were straighter? ___Yes ___No

3) Do you feel there is too much space in between your teeth? ___Yes ___No

4) Do you know all of the options available for enhancing your smile? ___Yes ___No

5) Do you feel that finances have prevented you from taking advantage of some of the options available to enhance your smile? ___Yes ___No

Comments:____

____

Please Do NOT write below this line.

- -

For Office Use Only

Comments:____

____

____

____________________ ____________________
Date **Initials**