Newton Dental Wellness Dr. Michaela Neagu DeSantis, DDS

Welcome To Our Office! To Assist Us In Treating You Please Complete The Following Confidential Forms.

First Name Middle Last Preferred Name

Date of Birth Marital Status Social Security Number

Street Address City State Zip

Home Phone Cell Phone Work Phone Email

Preferred method for Appointment Reminders? ○ Cell phone Text ○ Email

Occupation Employer

Whom may we thank for referring you?_____

Emergency Contact

Name Phone Number Relationship

Name Phone Number Relationship

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber's Name Date of Birth	Subscriber's Name Date of Birth
Street Address	Street Address
City State Zip	City State Zip
Dental Insurance Company	Dental Insurance Company
Group # Subscriber Id.#	Group # Subscriber Id.#
Employer	Employer

DENTAL HISTORY

Reason for seeking care today: ____ Exam ____ Cleaning ____ Specific Problem _____

_____

Please check all that apply:

- ○ Toothache
- ○ Broken filling or tooth
- ○ Food catches
- ○ Loose teeth
- ○ Floss breaks easily or hurts
- ○ Bite or teeth have shifted
- ○ Often bite cheek
- ○ Frequent dry mouth
- ○ Concerned about breath
- ○ Bad previous dental work
- ○ Gums bleed
- ○ Gums tender
- ○ Cold sores, fever blisters
- ○ Bad taste in mouth
- ○ Mouth breathe - Difficult
- ○ Clench or grind teeth
- ○ Jaw joint pain
- ○ Clicking or popping of jaw
- ○ Previous gum treatment
- ○ Previous bite treatment
- ○ Sensitivity to:
  - a) Cold
  - b) Hot
  - c) Sweets
  - d) Chewing

MEDICAL HISTORY

Physician's Name:_____ Phone:_____

Have you ever been hospitalized for any reason? (Explain):_____

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list:_____

_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other?_____

_____

Please check all that apply:

- ○ Injury to head or neck
- ○ Heart problems
- ○ Heart attack
- ○ Angina
- ○ Heart murmur
- ○ Scarlet, Rheumatic fever
- ○ Mitral valve prolapse
- ○ Irregular heartbeat
- ○ Pacemaker
- ○ High or low blood pressure
- ○ Artificial joint
- ○ Diabetes
- ○ HIV or AIDS
- ○ Kidney problems
- ○ Liver problems, jaundice
- ○ Cirrhosis, Hepatitis
- ○ Cancer
- ○ Radiation/ Chemotherapy
- ○ Respiratory problems
- ○ Bloody, persistent cough
- ○ Anemia
- ○ Sickle cell
- ○ Thyroid disease
- ○ Glaucoma
- ○ Bleed or bruise easily
- ○ Stroke
- ○ Epilepsy or Seizures
- ○ Parkisons
- ○ Alzheimers
- ○ Hives, rash, Herpes
- ○ Shortness of breath
- ○ Snoring, sleep apnea
- ○ Easily winded
- ○ No energy
- ○ Fainting or dizzy
- ○ Anxiety or nervous disorder
- ○ Insomnia

Any other illnesses not listed above?_____

I will inform this office of any changes in my health status. I certify that the above information is completed and accurate to the best of my knowledge.

Patient Signature:_____ Date:_____

NEWTON DENTAL WELLNESS
93 Union St Ste 408 | NEWTON MA, 02459 | (617) 244-4997

Financial Policy

Our policy is intended to control the ever rising costs of providing dentistry, while still maintaining individualized, quality care for our patients. We believe this policy will prove to be a service to you and your family.

1. Payment by appointment (This lets you spread the payments according to treatment plan).
2. 5% reduction in fees for major services (Prosthetics- Crown, Bridges, Veneers) that are paid in full at first appointment.
3. We accept personal checks, cash, MasterCard, Visa, Discover, and American Express.
4. Insurance on assignment
    a. We will file the claim for you and will do our very best to maximize your benefits
    b. We accept assignment to lower your immediate out-of-pocket expenditures
    c. We ask that you take care of your estimated portion of payment and any yearly deductible at the time of service, while we file the claim at the same time.
    d. We allow 60 days for the insurance to pay the claim, after 60 days the remainder becomes your responsibility.

Cancellations- We ask that patients call our office at least 24 hours prior to scheduled appointment to cancel/reschedule.

A fee of $50 is assessed for patients who miss or cancel more than once in a calendar year without a 24-hour notice.

There is a $35 fee for returned checks.

This policy will meet the needs of most families in our practice. We want to be flexible in these changing times and we will gladly answer any questions or concerns that you may have.

x _____

Patient Signature Date

(Please complete the back)

Newton Dental Wellness

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

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* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

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)

Newton Dental Wellness

PHONE MESSAGE CONSENT FORM

Your dentist(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL **NOT**:

- LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
- LEAVE INFORMATION ON AN ANSWERING MACHINE
- LEAVE INFORMATION ON A VOICE MAIL

Please read below and consider carefully whom you want to have access to your dental information.

I _____give Newton Dental Wellness my permission to leave phone messages regarding my dental care with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phone: (_____) _____ - _____ initials_____

My home answering machine/voice mail: (__) _____- _____ initials_____

My office/work voice mail: (_____) _____-_____ initials_____

My dental care may be discussed with the following:

My spouse: _____ at

(_____) _____-_____ initials_____

Other: _____ at

(_____) _____-_____ initials_____

_____ _____

Patient Signature Date