METROWEST PROSTHODONTICS
661 Franklin Street, Framingham, MA 01702
Tel: 508-620-6622 Fax: 508-620-5680 www.metrowestpro.com

NEW PATIENT INFORMATION

Patient Name:_____ Today's Date_____

Male Female Married Single Divorced Other_____

Social Security #:_____ Driver's License #:_____ Date of Birth:_____

Occupation:_____Employer:_____

Phone
(Home):_____Work:_____Cell:_____Email:_____

Address:_____
Street City State Zip Code

Emergency Contact:_____

Relationship:_____ Telephone #:_____

What is the purpose of your visit?_____

Whom may we thank for referring you to our practice?_____

PRIMARY INSURANCE INFORMATION

Name of Subscriber:_____Is the subscriber a patient? Yes No

Insurance Plan Name and Address:_____

_____Subscribers Date of Birth:_____

Subscriber ID #:_____ Group #:_____ Employer Name:_____

DENTAL HISTORY

How can we make your visit more comfortable?_____

Do you have a specific dental concern? Where?_____

Are you in pain? Cold Hot Sweet Throbbing Ache Where?_____

Do your gums ever bleed? Where?_____

Do you like your smile? Yes No If no, why not?_____

Does food catch between your teeth? Where?_____

Do you have clicking, popping, or discomfort in your jaws? Discuss_____

Do you grind your teeth at night or during the day? Discuss_____

Name of previous dentist:_____

Date of last full mouth xrays (21 small films or panoramic) if known:_____

Date of last dental visit and reason:_____

Personal Health Information

Do any of the following pertain to your health?

Acid Reflux	Epilepsy/Seizures	Mitral Valve Prolapse
Allergies/Hives	Fainting/Dizzy Spells	Nervousness
Anemia	Functional Heart Murmur	Nonfunctional Heart Murmur
Angina Pectoris	Glaucoma	Heart Disease/Attack
Pregnancy	Heart Failure	Psychiatric Treatment
Asthma	Heart Pacemaker	Radiation Therapy
Bruise Easily	Heart Surgery	Rheumatic Fever
Cancer/Leukemia	Hemophilia	Rheumatism
Chemotherapy	Hepatitis A/B/C	Scarlet Fever
Cold Sores	High Blood Pressure	Sickle Cell Disease
High Cholesterol	Stroke	Cortisone Injections
HIV/AIDS	Thyroid Disease	Diabetes
Kidney Trouble	Tuberculosis (TB)	Drug Addiction
Liver Disease	Ulcers	Dry Mouth
Low Blood Pressure	Yellow Jaundice	Emphysema

Prosthetic Heart Valves (Premedication required)
Bouts of Infective Endocarditis (Premedication required)
Cardiac transplant recipient who developed valvulitis (Premedication Required)
Joint replacement _____Date of Surgery_____(Premed first 2 years)
Rare and exotic congenital heart disease, excluding MVP (Mitral Valve Prolapse) (Premedication Required)
Osteoporosis, History of medicine to treat? (Actonel, Boniva, Fosamax, Reclast) Yes No

Any other medical conditions/current operations not listed? **Yes** (please list) **No**

_____

_____

Any allergies or adverse reactions to the following? **Yes** (please list) **No**

Aspirin	Local Anesthetic	Pine Nuts/Tree Nuts
Codeine	Mint	Sulfa Drugs
Dairy	Nitrous Oxide	Valium
Erythromycin	Penicillin	OTHER:_____
Latex	Percodan/Vicodin/Vicoprofen	

Please list all medicines you are currently taking:

_____

_____

_____

Primary Care Physician:
Name_____Phone#_____
Location_____

Permission for Dental Examination and Treatment
I do hereby authorize and consent to any x-rays, examinations, anesthetic, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Abramovitz and/or staff members they may deem necessary. This authorization will remain in effect until cancelled in writing by me.

PAYMENTS: ARE EXPECTED AT TIME OF SERVICE
APPOINTMENTS: 48 HOURS NOTICE IS REQUIRED TO AVOID CANCELLATION CHARGE
TRUTH IN LENDING: ACCOUNT BALANCES OVER 30 DAYS WILL BE SUBJECT TO AN INTEREST RATE CHARGE OF 18% PER ANNUM.

Patient/Parent/Guardian Signature:_____Date:_____
Staff Signature:_____Date:_____

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Payment Policy

Thank you for choosing our practice as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the highest quality service available. To help reduce our administrative costs and keep our fees as low as possible, we require payment in full at the time of service.

We accept the following forms of payment; please indicate below the method of payment you intend to use.

Cash
Checks
Major credit cards (Visa, Mastercard, American Express or Discover)
Interest free and monthly payment plans available through CareCredit and Citi Healthcard.

Insurance

We are committed to helping patients maximize their dental insurance benefits. However, dental insurance usually does not cover the total cost of treatment. We can estimate your coverage in good faith, but cannot guarantee it, and your copay will be expected at the time of treatment. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

Acceptance Agreement

The patient (account holder) agrees to be fully responsible for the total payment of treatment rendered in this office. Also, I understand the parent or relative bringing a child to dental treatment is responsible for all fees incurred at that visit. Any fees incurred to collect payment will be billed to and payable by the patient's account holder. I understand and agree with the above financial policy.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Please Print Patient/Responsible Party Date