dental studio associates

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Patient is: ☐ **Policy Holder** **Preferred Name:** _____

☐ **Responsible Party**

-----Patient Information-----

Address: _____ **Address 2**: _____

City: _____ **State/Zip** _____

Home Phone: _____ **Cellular:** _____ Work: _____

Email Address: _____@_____

☐ I would like to receive correspondences via e-mail ☐ I would like to receive correspondences via texting

We now text & Email confirmations and reminders! How would you like your reminders set?
(Please check which ones you would like to receive. These can ALWAYS be adjusted to more or less.)

☐1 month before scheduled appointment ☐ 1-2 weeks before ☐1-2 days before ☐ Same day reminder

Sex: ☐ Male ☐ Female **Marital Status:** ☐Married ☐Single ☐Divorced ☐Seperated ☐Widowed

Date of Birth: _____ Age: _____ SSN: _____

-----Insurance Information------

Policy Holder:

First Name: _____ Last: _____ Middle Initial: _____

Policy Holder's DOB: _____ Patient Relationship: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Employment Status: ☐ Full Time ☐ Part Time ☐ Per Diem ☐ Retired

Employer's (Place of employment) Name: _____

Insurance Company: _____ Effective Date: _____

Policy ID # (may be Policy holder's SSN) _____ Group #: _____

-----Secondary Insurance-----

First Name: _____ Last: _____ Middle Initial: _____

Policy Holder's DOB: _____ Patient Relationship: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Employment Status: ☐ Full Time ☐ Part Time ☐ Per Diem ☐ Retired

Employer's (Place of employment) Name: _____

Insurance Company: _____ Effective Date: _____

Policy ID # (may be Policy holder's SSN) _____ Group #:

DETAILED MEDICAL HISTORY

Patient's Name: _____ **DOB:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a drastic part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for taking the time to answer the following questions.

Are you under a physician's care now?	◯ YES ◯ NO	If yes, _____
Have you ever been hospitalized or had a major operation?	◯ YES ◯ NO	If yes, _____
Have you ever had a serious head or neck injury?	◯ YES ◯ NO	If yes, _____
Are you taking any medication, pills or drugs?	◯ YES ◯ NO	If yes, _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ YES ◯ NO	If yes, _____
Have you ever taken Fosamax, Boniva, Actonel? Or any other medication containing bisphosphates?	◯ YES ◯ NO	If yes, _____
Are you on a special diet?	◯ YES ◯ NO	If yes, _____
Do you use tobacco?	◯ YES ◯ NO	If yes, _____
Do you use controlled substances?	◯ YES ◯ NO	If yes, _____

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral Contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetics ☐ Other? _____

Do you have, or have you ever had, any of the following?

AIDS/HIV Positive ◯ YES ◯ NO	cortisone Medicine ◯ YES ◯ NO	Hemophilia ◯ YES ◯ NO	Radiation Treatment ◯ YES ◯ NO
Alzheimer's Disease ◯ YES ◯ NO	Diabetes ◯ YES ◯ NO	Hepatitis A ◯ YES ◯ NO	Recent Weight Loss ◯ YES ◯ NO
Anaphylaxis ◯ YES ◯ NO	Drug Addiction ◯ YES ◯ NO	Hepatitis B or ◯ YES ◯ NO	Renal Dialysis ◯ YES ◯ NO
Anemia ◯ YES ◯ NO	Easily Winded ◯ YES ◯ NO	Herpes ◯ YES ◯ NO	Rheumatic Fever ◯ YES ◯ NO
Angina ◯ YES ◯ NO	Emphysema ◯ YES ◯ NO	High Blood Pres ◯ YES ◯ NO	Rheumatism ◯ YES ◯ NO
Arthritis|Gout ◯ YES ◯ NO	Epilepsy|Seizures ◯ YES ◯ NO	High Choleste ◯ YES ◯ NO	Scarlet Fever ◯ YES ◯ NO
Artificial Heart Valve ◯ YES ◯ NO	Excessive Bleeding ◯ YES ◯ NO	Hives|Rash ◯ YES ◯ NO	Shingles ◯ YES ◯ NO
Artificial Joint ◯ YES ◯ NO	Excessive Thirst ◯ YES ◯ NO	Hypoglycemia ◯ YES ◯ NO	Sickle Cell Disease ◯ YES ◯ NO
Asthma ◯ YES ◯ NO	Fainting spells|Dizziness ◯ YES ◯ NO	Irregular Heartbeat ◯ YES ◯ NO	Sinus Trouble ◯ YES ◯ NO
Blood Disease ◯ YES ◯ NO	Frequent Cough ◯ YES ◯ NO	Kidney Proble ◯ YES ◯ NO	Spina Bifida ◯ YES ◯ NO
Blood Transfusion ◯ YES ◯ NO	Frequent Diarrhea ◯ YES ◯ NO	Leukemia ◯ YES ◯ NO	Stomach|Intestinal Disease ◯ YES ◯ NO
Breathing Problems ◯ YES ◯ NO	Frequent Headaches ◯ YES ◯ NO	Liver Diseases ◯ YES ◯ NO	Stroke ◯ YES ◯ NO
Bruise Easily ◯ YES ◯ NO	Genital Herpes ◯ YES ◯ NO	Low Blood Pre ◯ YES ◯ NO	Swelling of Limbs ◯ YES ◯ NO
Cancer ◯ YES ◯ NO	Glaucoma ◯ YES ◯ NO	Lung Disease ◯ YES ◯ NO	Thyroid Disease ◯ YES ◯ NO
Chemotherapy ◯ YES ◯ NO	Hay Fever ◯ YES ◯ NO	Mitral Valve Pr ◯ YES ◯ NO	Tonsillitis ◯ YES ◯ NO
Chest Pains ◯ YES ◯ NO	Heart Attack|Failure ◯ YES ◯ NO	Osteoporosis ◯ YES ◯ NO	Tuberculosis ◯ YES ◯ NO
Cold Sores|Fever Blisters ◯ YES ◯ NO	Heart Murmur ◯ YES ◯ NO	Pain in Jaw Joi ◯ YES ◯ NO	Tumors or Growths ◯ YES ◯ NO
Congenital Heart Disorders ◯ YES ◯ NO	Heart Pacemaker ◯ YES ◯ NO	Parathyroid D ◯ YES ◯ NO	Ulcers ◯ YES ◯ NO
Convulsions ◯ YES ◯ NO	Heart Trouble|Disease ◯ YES ◯ NO	Psychiatric Ca ◯ YES ◯ NO	Venereal Disease ◯ YES ◯ NO
			Yellow Jaundice ◯ YES ◯ NO

Have you ever had any serious illness not listed above? If yes, _____

Patient Signature:_____ **Date:** _____

GETTING TO KNOW YOUR DENTAL HISTORY…

Printed Patient Name: _____ **DOB:** _____

Nickname: _____ **How long have you been a patient?** _____ mos/yrs

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I routinely see my dentist/hygienists every: ☐ 3mo. ☐ 4mo. ☐ 6mo. ☐ 12mo. ☐ Not routinely ☐ As needed

Date of most recent treatment (other than a cleaning): _____ / _____ /_____

Were you referred to our office? YES | NO, If so by who? _____

WHAT IS YOUR IMMEDIATE CONCERN IF ANY? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY:		
1. Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) [_____]_____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetics? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ____	☐	☐
GUM AND BONE:		
1. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____	☐	☐
3. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
4. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
5. Have you ever experienced gum recession? _____	☐	☐
6. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_	☐	☐
7. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
TOOTH STRUCTURE:		
1. Have you had any cavities within the past 3 years? _____	☐	☐
2. Does the amount of salvia in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth? _____	☐	☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
5. Do you have any grooves or notches on your teeth near the gum line? _____	☐	☐
6. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
7. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT:		
1. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
2. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
3. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry food? __	☐	☐
4. In the past 5 years, have your teeth changed? (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
5. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
6. Are your teeth developing spaces or becoming more lose? _____	☐	☐
7. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make teeth fit?	☐	☐
8. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
9. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
10. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
11. Do you have problems with sleep? Wake up with a headache or an awareness of your teeth? (i.e. grinding) _____	☐	☐
12. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS:		
1. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
2. Have you ever whitened (bleached) your teeth? _____	☐	☐
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
4. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient Signature:_____ **Date:** _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have
(please print first and last name)
reviewed and received a copy of this office's Notice of Privacy Practices, which you may request at the front desk, explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

Please check all that apply

☐ I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon requests.

☐ I also understand that if I have any questions or concerns, I may contact:

DENTAL STUDIO ASSOCIATES, LLC
302 SUFFIELD STREET,
AGAWAM, MA. O1001
413-786-0085

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient Full Name: _____ Date: _____
(please print full name)

Pt Signature/Representative: _____ Date: _____

If Pt cannot sign, what is your relationship to patient: _____

FOR OFFICE USE ONLY

We made good-faith effort to obtain an acknowledgment of _____'s, receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment for receipt for the following reasons (check all that apply):

____ Patient refused to sign (date of refusal) _____/_____/_____.

____ Communications barriers prohibited obtaining an acknowledgment.

____ An emergency situation prevented us from obtaining an acknowledgment.

____ Other_____

Attempt was made by: _____ Date: ____/_____/_____

PATIENT CONSENT & AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (HIPAA)

PATIENT INFORMATION---

Patient Name: _____ DOB: _____

Address: _____

City: _____State: _____Zip Code: _____ Phone #: _____

E-mail Address: _____

I, _____, hereby authorize the release, use or disclosure of my health information to **Dental Studio Associates, LLC**. This authorization pertains to the follow type of medical/dental information about me: **DENTAL**

I understand that, per my request, this authorization will permit the named parties listed below to use or disclose the identified health information for purposes beyond treatment, payment or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that I may revoke this authorization or change it at any time by providing a written notice to:
Dental Studio Associates, LLC
302 Suffield Street, Agawam, MA 01001
(413)786-0085
Unless I request in writing otherwise, I understand that this authorization will not expire.

I understand that the information used or disclosed pursuant to this authorization may be subject to re disclosure by the named recipient and may no longer be protected by HIPPA's privacy rule after the authorized disclosure.

The names listed below may be able to, but not limited to:

- call on my behalf
- make appointments on my behalf
- pay on my account
- Request printouts of receipts or account balances.
- Request my records
- Request information regarding continuing care.

I hereby authorize **Dental Studio Associates, LLC** to release the above described information to:

(1) **Full Name:** _____

Relationship: _____ **Phone #:** _____

(2) **Full Name:** _____

Relationship: _____ **Phone #:** _____

(3) **Primary Care Physician:** _____ **Phone #:** _____

Patient Signature:_____ **Date:** _____

Courtesy 48 Hour Cancellation & Rescheduling Policy

Your appointments are very important to us. They are reserved especially for you. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least a 48 business hour notice for any and all cancellations or rescheduling of appointments.

Please understand that when you forget, cancel, or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and patients on our wait list miss the opportunity to receive treatment.

Any appointment missed, cancelled, or changed without a 48 hour notice will result in a fee.

As a courtesy, your appointments are confirmed electronically the week and day before your scheduled appointment by email and/or text message from our online appointment scheduling software because we know how easy it is to forget an appointment you booked months ago. From this confirmation email, text or voice call, you have the option of the following with no charge:

- Confirm your appointment from the link provided in the email or text.
- Cancel your appointment via text or email.
- Respond back by email or text with any changes or issues.
- Call our office number which is provided in the email and text.
- TEXT US regarding your appointment.

Please understand that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us the day before is not sufficient reason to miss an appointment if the original confirmation notification was received timely. A link to automatically upload the appointment to your calendar is provided on every electronic confirmation.

Any late arrival will shorten your appointment time and will not be made up by running into the next patient's scheduled appointment. One of our staff will call any patients 10 minutes past the hour of the scheduled appointment to verify the appointment status. One of our staff members will also call you, the patient, 10 minutes before his or her appointment If your provider is running behind as well and your appointment will be adjusted accordingly or rescheduled if desired with no fee.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, staff member emergency or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or charges will apply.

Dental Studio Associates, LLC reserves the right to modify a scheduled appointment to a different provider during the same allotment if circumstances arises without prior approval of the patient.

The 48 hour cancellation policy gives us time to inform our wait list patients of any availability, as well as keeping our staff schedules filled, thus better serving everyone. Dental Studio Associates, LLC policies are presented and provided in the best quality and tradition of excellent service for our established and future patients. Thank you for viewing, reading and supporting our 48 hour cancellation and rescheduling policy criteria!

I HAVE READ AND AGREE TO ALL TERMS AND CONDITIONS:

Patient Name (please print): _____

Signature of Patient/Guardian: _____ **Date:** _____

OFFICE FINANCIAL POLICY [UPDATED 2019]

Thank you for choosing **Dental Studio Associates, LLC**. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible. We can do this by offering different payment options.

PAYMENT OPTIONS: [you can choose from the following]

Cash or Check: When treatment is paid in full at the completion of services, we extend a discount courtesy to our patients with no dental insurance.
Credit Card: We accept VISA, MasterCard, or Discover.
CareCredit: (this is a NO INTREST payment plan): Benefits to this payment option can be as follows:

* Allows you to pay over time with **NO INTEREST**.
* Convenient, low monthly payment plans are available.
* No annual fees or pre-payment penalties

PAYMENT TERMS:
Dental Studio Associates, LLC required payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For plans requiring more than 2 appointments, alternative payment arrangements may be provided. For patients with dental insurance, we are happy to work with you and your carrier to help you maximize your benefits. As a courtesy we will also submit all claims directly to your carrier for treatment provided.

NOTE: All copays are due at the completion or time of service.

We do our best with pre-treatment insurance estimates for you to be aware what your estimated patient portion will be. Please be aware that insurance at ANY time can still deny or pay less than the estimated portion told to us. Any balance after insurance pays is ultimately yours, the patients, responsibility.

PLEASE REMEMBER: Insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is patient responsibility to pay any deductible, co-insurance or any other balance not paid by their dental insurance. The patient/responsible party agrees to pay a 1.5% interest charge per month on all cost of collection to include attorney fees on all amounts due to accounts more than 90 days from the date of service and when all open insurance claims have been closed. To the extent necessary to assign all dental benefits to which I am entitled, including private insurance and other health plans to: Dental Studio Associates, LLC. Assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as vaild as the original, I understand that I am financially responsible for all charges whether or not paid by said dental insurance. I understand that if payments are not to be made and my account is more than 90 days delinquent after all dental claims have been closed, I give permission to Dental Studio Associates, LLC to turn my account over to any outside source for collection efforts. I understand that all dental procedures performed by the doctor are necessary and I waive any defense to the contrary.

I have read and agree to all terms and conditions:

Patient Name (please print): _____

Signature of Patient/Guardian: _____ **Date:** _____

dental studio associates

302 Suffield Street Agawam, MA 01001 || (p) 413-786-0085 || (f) 413-786-0025

DENTAL RECORD REQUEST

Patient Name: _____ **DOB:** _____

☐ **I am requesting my dental records from my previous office.**

I authorize Dental Studio Associates to request and receive any and all previous dental or medical charting as they pertain to the above named patients dental health and treatment.

Previous Dentist/Office Name: _____

Address/Location (if known): _____

Office Phone Number: _____ Office Fax: _____

Notes: _____

_____

Please email x-rays and information if possible to ***thedentalstudio09@gmail.com***

☐ **I am transferring my records…**

I authorize Dental Studio Associates to transfer all previous dental or medical charting as they pertain to the above named patients dental and treatment to the following office

Transferring Office Name: _____

Address/Location (if known): _____

City/State/Zip: _____

Office Phone Number: _____ Office Fax: _____

Only dental x-rays and periodontal chartings from the past five (5) years will be disclosed, unless otherwise mentioned.

_____ _____

Printed Name of Patient or Legal Guardian | Date of Birth

_____ _____

Signature of Patient or Legal Guardian if under 18 years of age | Today's Date

Please indicate if someone other than yourself will be picking up your records:

_____