Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

			Patient #		
Dationat Informe	ti an		SS#/SIN		
Patient Informa	Date	Date			
	Home Phone_				
NameAddress	<u> </u>	City	State/ Prov		
Email		Cell Phone			
Check Appropriate Box: Minor If Student, Name of School/College]Single □Married □Divorce	:d □ Widowed □	Separated State/	_FullPart	
Patient or Parent/Countries Employe	***	· City ———	Prov L	∃Iime ∐ Tim	
If Student, Name of School/College — Patient or Parent/Guardian's Employe Business Address		- Cri	Work Phone <u>. </u>	Zip/	
Spouse or Parent/Guardian's Name _					
Whom may we thank for referring yo					
Person to contact in case of emergence			Phone	7000	
Responsible Par	ty				
Name of Person Responsible for this A	~		Relationship to Patient		
Address			Home Phone		
Email					
Driver's License#					
Employer					
Is this person currently a patient in ou					
For your convenience, we offer the follo	***	eck the ontion you prefer	Parment in full at each	annaintment	
☐ Cash ☐ Personal Check	Credit Card 🗆 VISA 🗵	MasterCard Uwi	sh to discuss the office's	nament police	
] AMEX	on to abous the office s	граупкт рошу.	
Insurance Inform	nation		Relationshin		
Name of Insured					
Birthdate	SS#/SIN		Date Employed		
Name of Employer	Uni	on or Local#	Work Phone	7in/	
Address of Employer	-			Zip/ P.C.	
Insurance Company	Grou	up#	Policy/ID#	7:	
Ins. Co. Address				Zip/ P.C.	
How much is your deductible?	How much have you	used?	_Max. annual benefit.		
DO YOU HAVE ANY ADDITIONA	L INSURANCE? Yes	No IF YES, CON	APLETE THE FOLLOV	VING:	
Name of Insured			Relationship to Patient		
Birthdate	SS#/SIN				
Name of Employer			1 /		
Address of Employer			State/ Prov	Zip/ P.C.	
Insurance Company	~ · · · · · · · · · · · · · · · · · · ·				
Ins. Co. Address		_	State/ Prov	Zip/ P.C.	
How much is your deductible?	•				
-	Over Pleas				

Physician	History Office P	hone			D	Date of Last Exam			
		Yes No				1		Yes	N
L. Are you under medical treatment now:	?	🗆 🗆				act lenses? you had any reactions to t		Ш	L
Have you ever been hospitalized for ar	ny		TO.AME	yuuullergi ol Anac+l	n wornave) hatics (a c	you naa any reactions to t Novocain)	in John Wilk:		-
surgical operation or serious illness wi	ithin the last 5 years?		_ Loca Peni	icillin or	anv other	Antibiotics			Ī
If yes, please explain						Antibiotics			į
	<u> </u>								ĺ
3. Are you taking any medication(s)									
including non-prescription medicine?.		🗆 🗀	_					f 1	[
If yes, what medication(s) are you tak	ting?								Ĺ
			Any	Metals	(e.g. nickel	l, mercury, etc.)	,	=	إ
4. Have you ever taken Fen-Phen/Redux	?	🔲 🖺	Late	ex Rubbe	er			لــا	-
5. Have you ever taken Fosamax, Boniva, .	Actonel or any cancer		Oth	er (pleas	se list)	. 1 1 .1 .			
medications containing bisphosphonate		🗆 🗆				t cough or throat dearin			ſ
6. Do you use tobacco?						illness (lasting more tha	n 3 weeks)?		-
7. Do you use controlled substances?				men On			vama (******		ſ
7. Do you ase controlled substances:						r think you may be p			
8. Do you have or have you had any of ti	he following?		b) A	re you r	nursing/	contracontinas?		님	ļ
6. Do you have or have you had any by the			c) A	ire you t Yes	taking orat No	contraceptives?		Yes	l N
	Yes No			162	_	ant Daire		162	1
High Blood Pressure		ease		H	_	nest Pains		\exists	Ĺ
Heart Attack		Pacemaker		Ħ		isily Winded		=	Ĺ
Rheumatic Fever		rmur		Ħ		roke 2y Fever / Allergies		Ē	ŗ
Swollen Ankles Fainting / Seizures	Frequently	y Tired				zy Fever / Allergies berculosis		\vdash	į
Asthma						idiation Therapy			ĺ
Low Blood Pressure		ma				аисотааистиру		Ħ	ř
Epilepsy / Convulsions	☐ ☐ Cancer			닏		cent Weight Loss			ř
Leukemia				\vdash		ver Disease			Ī
Diabetes		lacement or I		إحا		eart Trouble			Ì
Kidney Diseases	Hepatitis	/ Jaundice Transmitted 1	Dicago	님		spiratory Problems			
AIDS or HIV Infection	Sexually Sexually	Transmitted I Troubles / Ul	viseuse	H		itral Valve Prolapse.			Ĺ
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Thyroid Problem	Osteonom	sis				ther			Ĺ
Acid Reflux	Osteoporos	sis							L
Acid Reflux	Osteoporos	sis							L
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Acid Reflux	□ □ Osteoporo: History	sis	No		D	ther Date of Last Exam _		Yes	N
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GREENLEAF DENTALCARE

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provide	d		
I understand that during my course	of treatment that the foll	owing care may be	provided:
Examinations X Preventive Service	es (including x-rays) X	Restorations X	Patient Initials:
2. Drugs and Medications			
I understand that antibiotics, analges swelling of tissues; pain, itching, vo		_	ic reactions causing redness and Patient Initials:
3. Changes in Treatment P.	lan		
I understand that during treatment it while working on the teeth that were following routine restorative proced as necessary.	e not discovered during e lures. I give my permissi	examination, the mo	ost common being root canal therap make any/all changes and additions Patient Initials:
4. If applicable, I give permiss	sion for this the dent	al office to bill n	ny dental insurance provider
for the treatment provided	•		Patient Initials:
Patient Signature		Date	
Print Name:			

Consent For Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name:			
Date Of Birth:			
SECTION B: PE	EASE READ THE FOLLOWING STATEM	ENTS CAREFULLY	
	t: By signing this form, you will consent to our use an et activities and healthcare operations.	d disclosure of your prote	ected health information to carry out
description of our t	ractices: You have the right to read our Notice of Priv reatment, payment activities and healthcare operati formation, and of other important matters about yo	ons. In addition, the uses	and disclosures we may make of your
We reserve the right issue a revised Noti	nt to change our privacy practices as described in our ce of Privacy Practices. Changes may apply to any of	Notice of Privacy Practice your protected health inf	es. If we change our privacy practices, we will formation that we maintain.
You may obtain a co	opy of our Notice of Privacy Practices, including any a	evisions of our Notice, at	any time by contacting:
Contact Person:	CATHERINE T. HARDY (OFFICE MANAGER)	TELEPHONE:	978-374-7942
Contact Person liste	ou will have the right to revoke this Consent at any tiled above. Please understand that revocation of this Coyour revocation and that we may decline to treat yo	Consent will not affect any	action we took in reliance on this Consent
signing this Consent	rtunity to read and/or consider the contents of this (form, I am giving my consent to your use and disclosed the contents of	Consent form and your No Sure of my protected heal	otice of Privacy Practices. I understand that, by Ith information to carry out treatment,
Signature:		Date:	
If this Consent is sign	ned by a personal representative on behalf of the pa	tient, complete the follow	ring:
Personal Representa	ative's Name:	Relations	hip:
REVOCATION:			
I revoke my Consent operations.	for your use and disclosure of my protected health i	information for treatment	t, payment activities and healthcare
	vocation of my Consent will not affect any action you n. I also understand that you may decline to treat or i		
Signature:		Date:	

PAYMENT POLICY

- 1. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less that anticipated.
- 2. Your portion is payable at each visit.
- 3. As a courtesy, we will fill out your claim forms with you, answer any questions we can and try to help you get the most benefit out of your particular policy.
- 4. We accept cash, checks, mastercard and visa.
- 5. Financing is available through <u>CARE CREDIT</u>, there are no in-office payment plans.
- 6. Due to unforeseen circumstances in dentistry, original treatment plans are subject to change.
- 7. If you miss and/or same day cancel three (3) appointments you will be dismissed from the practice.

Thank you for your cooperation.

Signature	Date	