884 Washington St.
Weymouth, MA 02189
(781) 340-5361

Patient Registration

Pt Chart #_____

Patient_____
Last Name First Name Initial Preferred Name

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

Email_____

Sex_____ Age_____ Birthday_____ ☐ Single ☐Married ☐Widowed ☐Separate ☐ Divorced

Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Spouse/Parent Name_____ Spouse/Parent Birth Day_____

Spouse/Parent Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Who is responsible for this insurance? Self___ Spouse____ Parent___

Social Security #_____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company_____ Insurance ID #_____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for referring you?_____

I am to assign directly to Dr. Olga Krasnoslobodtseva all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature_____ Date_____

MINOR/CHILD CONSENT

I, being the parent of _____do hereby request Name of minor/child and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which is deemed advisable by doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Insured/Guardian_____ Date_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

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Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient name _____ Preferred name _____
If minor, parents' names
_____

Do you have / have you had any of the following?
(Please check any that apply)

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial joints

Date of surgery:

- ❑ Asthma
- ❑ Auto-immune disorders
- ❑ Blood disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Peacemaker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolepse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Pregnant (currently)
- ❑ Radiation Treatment
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach Disease
- ❑ Stroke
- ❑ Swelling of Limb
- ❑ Tobacco Use
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Name of physician _____ Phone number _____
Address _____ Last exam date _____
Allergies:_____
Major operations:_____
Medications (prescriptions, over the counter, herbal supplements, etc.):
_____
_____
Do you require antibiotic premedication prior to dental treatment? _____ Yes _____ No
Do you have any disease, condition, or problem not listed above? _____ Yes _____No
If yes, please explain: _____
Signature of patient, parent, or guardian_____ Date_____
_____ RDH / DMD _____
Reviewed by Date

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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 Provided**
   I understand that during my course of treatment that the following care may be provided: Examinations____ Preventive Services ___ Restorations ___ Crowns___ Bridges ___ Other___ ***Patient Initials_____**
2. **Drugs and Medications**
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). ***Patient Initials_____**
3. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. ***Patient Initials_____**
4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. ***Patient Initials_____**

Patient Signature_____Date_____

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PATIENT PAYMENT POLICY

Please read carefully the following statement. Patient or guardian signature is required before treatment commences.

Our patients are special to us, we care about you. Your dental health and your financial responsibilities are our concern as well as yours. Our payment policy is explained below in order for you to easily understand it.

Due to the high cost of billing, payment is expected at the time of service for any office procedure, including initial consultation and X-rays. For those patients covered by insurance we will be happy to assist you in filling your insurance form for reimbursement. However, insurance company rarely pays the entire total, even if your policy states you have 100% coverage.

If you prefer to delay your treatment, we will request a pre-determination of payment from your insurance company. This generally takes 4-6 weeks for a response. At the time of your procedure, you will only be required to pay the amount not covered by your particular insurance.

All patients will receive invoices every month. If we are processing your claim from this office and the account is not cleared within 30 days, we ask you to contact the insurance carrier for an explanation. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check, MasterCard or Visa. Account balances over 90 days past due will be forwarded to collection agency or we will take to small claims court.

Our cancellation policy requires a 48 hour notice, If you do not provide 48 hours there will be a $50 charge for each hour you where scheduled for. Insurance does not pay for this it will be your responsibility to pay this fee.

MassHealth Patients: If you cancel, do not show or miss your appointment without the required notice we will notify Mass Health of the broken appointment. Mass Health may revoke your coverage if an excessive number of broken appointments are reported.

All payments are ultimately the responsibility of the patient or guardian. Our staff is here to assist you in any way possible.

We understand that temporary financial problems may affect timely payment of your balance.

We encourage you to communicate with us, any such problems so that we may assist you in the management of your account.

Groupon certificates can only be used one time per patient in this office. These offers cannot be combined with any other offer.

Again, thank you for choosing us as your dental care provider.

Patient Signature_____Date_____

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HIPPA Privacy Authorization Form

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOU HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY we are required by the applicable Federal Law to maintain the privacy of your information. We are also required to give you this notice about our private practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment and healthcare operations. For Example: Treatment: We may use or disclose your health information to a physician or other healthcare providers, providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you.

You're Authorization: In addition to our use of your health information for treatment, payments, healthcare operations, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing anytime. Your revocation will not affect any use of disclosures permitted by your authorization while in effect.

Persons involved in Care: We may use or disclose health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location. Your general condition or death. In the event of incapacity or emergency circumstances, we will; disclose health information based on determination using our personal judgment disclosing health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Appointment Reminders: We may use or disclose your health information to provide your appointment reminders (such as voicemails messages, postcards, letters, or emails.)

PATIENT RIGHTS You must make a request in written to obtain your x-rays. We will charge you a reasonable cost-based fee expenses such as copies and staff time.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

Print Name_____

Signature_____ Date_____

I am giving (Name)_____ (Relationship) _____

To speak to Dental Aid1 doctor and staff about my treatment and conditions and scheduled appointments.

Patient Signature _____ Date _____