TODAY'S DATE_____

PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME		NICKNAME OR PREFERRED NAME
EMAIL				
ADDRESS				BIRTHDATE
CITY	STATE	ZIP		☐ MALE ☐ MARRIED ☐ FEMALE ☐ SINGLE
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED		SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT ☐ PARENT ☐ GRANDPARENT ☐ OTHER ☐ LEGAL GUARDIAN	
	EMAIL ADDRESS			
	ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER (PLEASE SPECIFY)_____				

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS

WHOM MAY WE THANK FOR REFERRING YOU? PLEASE PROVIDE FULL NAME	ARE THEY A PATIENT HERE?	☐ YES ☐ NO – CHOOSE BELOW
HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ OUR WEBSITE ☐ BUILDING SIGN ☐ YOUR EMPLOYER ☐ MAILER/UNION HALL ☐ PUBLIC EVENT ☐ INSURANCE COMPANY ☐ ONLINE SEARCH ☐ SOCIAL MEDIA ☐ DENTAL CENTER EMPLOYEE_____		

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

PLEASE TURN OVER AND SIGN...

PATIENT REGISTRATION

ACKNOWLEDGEMENT & CONSENT

Acknowledgement of Insurance Payment Authorization: I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Access Dental/Blue Hills Dental. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Access Dental/Blue Hills Dental.

Acknowledgement of Financial Responsibility: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that either a 1-½% late charge (18% APR) or a $15 late charge per late payment may be added to my account. I further agree to inform Access Dental/Blue Hills Dental of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize Access Dental/Blue Hills Dental to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.

Notice of Privacy Practices: I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Acknowledgment of Dental Materials Fact Sheet: I acknowledge that I have received and read the Dental Materials Fact Sheet prior to starting restorative dental work at Access Dental/Blue Hills Dental.

PATIENT SIGNATURE DATE

PARENT/RESPONSIBLE PARTY SIGNATURE DATE

RELATIONSHIP TO PATIENT

PATIENT NAME_____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete both sides of this dental & medical history form. All information is completely confidential and subject to all applicable laws.

Have you had the following disease or problems? **Active Tuberculosis** ☐ YES ☐ NO **Cough that produces blood** ☐ YES ☐ NO
IF YOU ANSWER YES TO EITHER OF THE QUESTIONS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

What is the reason for your visit today?_____

_____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full-Mouth X-rays**_____

How often do you brush your teeth?_____ How often do you floss?_____

Are any of your teeth sensitive to…?	YES	NO
Hot or Cold?	☐	☐
Sweets?	☐	☐
Biting or Chewing?	☐	☐

Have you noticed or experienced…?	YES	NO
Mouth odors or bad tastes?	☐	☐
Cold cores, blisters, or other mouth lesions?	☐	☐
Bleeding or painful gums?	☐	☐
Loose teeth or changes in your bite?	☐	☐
Does food tend to get caught between your teeth?	☐	☐

Have you ever had…?	YES	NO
Orthodontic Treatment?	☐	☐
Do you wear a retainer?	☐	☐
Oral Surgery?	☐	☐
Periodontal Treatment?	☐	☐
Your teeth or bite adjusted?	☐	☐
A full/partial denture?	☐	☐
How old is it?	_____	
A mouth guard?	☐	☐
How old is it?	_____	

Do You…?	YES	NO
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your cheeks, lips or fingernails regularly?	☐	☐
Hold foreign objects with your teeth? (i.e., pens, pipe, nails)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws especially in the morning?	☐	☐
Snore or have any other sleeping disorders?	☐	☐
Smoke/chew tobacco or use other tobacco products?	☐	☐
Drink coffee or tea?	☐	☐

If you could change your teeth…?	YES	NO
Whiter?	☐	☐
Straighter?	☐	☐
Remove space?	☐	☐
Replace metal fillings w/ tooth colored fillings?	☐	☐
Repair chipped teeth?	☐	☐
Replace missing teeth?	☐	☐
Replace old crowns that don't match?	☐	☐
Less gums showing?	☐	☐

	YES	NO
Do you feel nervous about dental treatment?	☐	☐

	YES	NO
Are you satisfied with your teeth appearance?	☐	☐

If so, what's your biggest concern?_____

_____

_____

_____

Have you had any medical care within the past two years? ☐ YES ☐ NO

Physician's Name_____ Phone (_____)_____

Describe_____

_____

CONTINUED ON OTHER SIDE…

Access Dental | Blue Hills DENTAL

MEDICAL HISTORY

The following questions are for your benefit and assure that any dental treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question.

1. Have you taken any medication or drugs during the past two years? ☐ YES ☐ NO
2. Are you currently taking any medication, drugs, pills or herbal remedies, including dosages of aspirin? ☐ YES ☐ NO
   If YES, please list name and dosage_____
3. Are you sensitive or allergic to any substance(s) or medication? ☐ YES ☐ NO
   If YES, please check all that apply ☐Aspirin ☐ Codeine ☐ Darvon ☐ Demerol ☐ Erythromycin ☐ Latex ☐ Nitrous Oxide
   ☐ Penicillin ☐ Percodan ☐ Sulfa Drugs ☐ Tetracycline ☐ Valium ☐ Vicodin ☐ Metals ☐ Other_____
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ YES ☐ NO
   If YES, did you take any of the following: ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other_____
5. Have you ever taken osteoporosis or bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ YES ☐ NO
6. Have you been a patient in the hospital during the past five years? ☐ YES ☐ NO
7. Have you ever had a serious injury to your head or mouth? ☐ YES ☐ NO
8. Have you ever been told to take a pre-medication prior to dental treatment? ☐ YES ☐ NO
9. Is there anything else about having dental treatment that you would like us to know? ☐ YES ☐ NO
   Please explain_____
10. Have you lost or gained more than 10 pounds in the past year? ☐ YES ☐ NO
11. Do you have, or have you had any disease, condition, or problem not listed? ☐ YES ☐ NO
12. If, please list_____
13. Indicate which of the following you have had, or have at present. Check "YES" or "NO" to each item.
    NOTE: Certain medical conditions may require a medical consultation with your primary care physician prior to the start of any dental treatment.

	YES	NO		YES	NO		YES	NO
A.I.D.S./H.I.V. Positive	☐	☐	Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Diet (Special/Restricted)	☐	☐	Nervous Disorders	☐	☐
Arthritis/Rheumatism	☐	☐	Difficulty Swallowing	☐	☐	Nervousness/Anxiety	☐	☐
Artificial Heart Valve/Pacemaker	☐	☐	Drug Addiction	☐	☐	Neurological Disorders	☐	☐
Artificial Joints	☐	☐	Emphysema	☐	☐	Osteoporosis	☐	☐
Artificial Prosthesis	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric/Psychological Care	☐	☐
Asthma	☐	☐	Excessive Bleeding	☐	☐	Radiation Therapy	☐	☐
Blood Disease or Bleeding Disorder	☐	☐	Fainting or Dizzy Spells	☐	☐	Rheumatic Fever	☐	☐
Blood Transfusion	☐	☐	Glaucoma	☐	☐	Scarlet Fever	☐	☐
Bruise Easily	☐	☐	Hay Fever/Allergy/Hives	☐	☐	Sickle Cell Anemia	☐	☐
Cancer, Tumors, Growths	☐	☐	Head Injuries	☐	☐	Sinus Trouble	☐	☐
Cerebral Palsy	☐	☐	Heart Attack, Disease, Surgery	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Heart Failure	☐	☐	Swollen Ankles	☐	☐
Chest Pain	☐	☐	Heart Murmur	☐	☐	Thyroid Problems/Disease	☐	☐
Chicken Pox	☐	☐	Hemophilia	☐	☐	Tonsillitis	☐	☐
Chronic Cough	☐	☐	Hepatitis A B C (CIRCLE WHICH ONE)	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Herpes	☐	☐	Ulcers	☐	☐
Congenital Heart Disease	☐	☐	High/Low Blood Pressure	☐	☐	Venereal Disease	☐	☐
Contact Lenses	☐	☐	Kidney Infection or Disease	☐	☐	Other (Please list below)	☐	☐
Cortisone Medicine	☐	☐	Liver Disease/Jaundice	☐	☐	_____		

WOMEN

14. Are you pregnant or think you could be pregnant? ☐ YES _____ Months ☐ NO Are you currently nursing? ☐ YES ☐ NO
15. Do you use birth control prescriptions? ☐ YES ☐ NO
16. Do you have any problems associated with your menstrual period? ☐ YES ☐ NO

I have answered all questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my health or medication.

PATIENT SIGNATURE DATE DENTIST REVIEW SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE _____ /_____ /_____

PATIENT: Any changes to your health history?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE _____ /_____ /_____

PATIENT: Any changes to your health history?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE _____ /_____ /_____

PATIENT: Any changes to your health history?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

INFORMED CONSENT

PATIENT NAME_____ **CHART NO.:**_____

1. a. **ARBITRATION**

   Arbitration is the final process for the resolution of any dispute or controversy between a patient, or a personal representative of the patient, as the case may be, and Access Dental/Blue Hills Dental concerning the quality of patient services provided to a patient under this agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this agreement. By entering into this agreement, the patient agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

   I. Patient understands and agrees that any and all disputes between patient and Access Dental/Blue Hills Dental or its providers shall be resolved by submission to binding arbitration conducted by the AAA. Such Disputes or controversies include, but are not limited to, complaints concerning the quality, necessity or outcome of services provided pursuant to this Informed Consent Form, as well as the construction, interpretation, performance or breach of the terms of this Informed Consent Form.

   II. Patient further recognizes that by consenting to binding arbitration, patient is giving up the right to have such disputes decided in a court of law and/or before a jury. A declaration of a court or other tribunal of competent jurisdiction that any portion of this agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable.

   b. **INITIATION OF ARBITRATION**

   Arbitration can be initiated by filling a demand for arbitration with the AAA, located at 225 Bush Street, 18TH Floor, San Francisco, CA 94104-4207, telephone number (415) 981-3901. A demand form may be obtained from the AAA.

   c. **COSTS**

   In all arbitration matters submitted to the AAA, the party initiating demand for the arbitration shall advance all administrative fees connected therewith.

   d. **LOCATION**

   Arbitration proceedings shall occur in the county where the patient's treatment was performed, unless all parties to the arbitration otherwise agree in writing.

   e. **FORM OF DECISION**

   The parties agree that the arbitrators shall issue a written opinion. The award of the arbitrators shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator.

2. **WORK TO BE DONE**: I understand that the following procedures may be performed on me as part of my dental treatments: X-rays, Fillings, Bridges, Crowns, Extractions, Impacted Teeth Removal, Root Canals, Dentures, Partial Dentures, Periodontal Treatments and possible other dental treatments.
3. **FILLINGS**: Fillings are procedures in which the dentist removes decayed tooth structure or a faulty restoration and replaces it with Composite Resin or Silver Amalgam fillings. I understand that these procedures could cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the time, these sensitivities are temporary and they will go away within one (1) or two (2) weeks. However, there are times that due to the depth of the filling in the tooth, the pulp or the nerve of the tooth becomes irreversibly sensitive. In these cases, the tooth will need to be treated for root canal therapy and might possibly require a post and a crown to be fully restored. I understand that the dentist cannot guarantee that the teeth receiving fillings will not need to receive the above mentioned additional procedures and that I will be responsible for payments for any additional treatments needed to restore the teeth, if the initial filling procedure does not correct the problem.
4. **DRUG AND MEDICATIONS**: I understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, pain, vomiting and/or anaphylactic shock (severe allergic reaction).
5. **CHANGES IN TREATMENT PLAN**: I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.
6. **REMOVAL OF TEETH**: Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth outlined in the treatment plan and any others necessary under paragraph #5. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.
7. **ANESTHESIA**: I realize the risks involved in receiving a local anesthetic, some of which are facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness. I also understand in rare instances patients may have allergic reactions to anesthetic, which may require emergency medical attention, or find that anesthesia reduces the ability to control swallowing, which increases the chance of swallowing foreign objects during treatment.
8. **CROWNS, BRIDGES AND CAPS**: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I don't have the permanent crown(s) placed, permanent serious damage or loss of the

INFORMED CONSENT

tooth/teeth involved may ensue, and that if I delay placement I may cause the teeth involved to move making the permanent crown not fit properly. I also understand the lower edge of a crown is usually designed to rest near the gumline, which may increase the chance of gum irritation, infection or decay. Proper brushing and flossing at home, a healthy diet and regular professional cleanings are essential to help prevent these problems.

9. **DENTURES – COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change
10. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth, and that complication can occur from treatment. Occasionally a root canal instrument will break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment can be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical steel, so this causes no harm). It may also be necessary to perform an apicoectomy to seal the root canal. As a result of filing in the root canal, the incomplete formation of your tooth, or an abscess at the end of the tooth (called the apex), an opening may exist between the root canal and the bone or tissue surrounding the tooth. This opening can allow filling material to be forced out if the canal into the surrounding bone and tissue. An apicoectomy may be necessary for retrieving the filling material and sealing the root canal. Teeth that receive root canal treatment may be more prone to cracking and breaking over several years' time, which may ultimately require a bridge or partial denture.
11. **PERIODONTAL (TISSUE AND BONE) TREATMENT**: I understand that I have a serious condition, causing gum and bone inflammation or bone loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions.

I hereby request and authorize the Dentists and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, (Paresthesia), fractured jaw, Temporomandibular Joint (TMJ) Complication, which could cause localized and systemic pain requiring future treatments including joint surgery, etc., have been clearly explained to me.

CONSEQUENCES OF NOT PERFORMING TREATMENT: This course of treatment will help to relieve your symptoms. If no treatment were performed, you would continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding your teeth, changes to your bite, discomfort in your jaw joint and possibly the premature loss of these and other teeth.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

PATIENT/PARENT/RESPONSIBLE PARTY SIGNATURE DATE

WITNESS SIGNATURE DATE

DOCTOR SIGNATURE DATE