MODERN DENTISTRY
of Shrewsbury

PATIENT INFORMATION

Patient Last Name: _____ First: _____ MI _____
Preferred Name: _____ Sex: ____M ____F Birth Date: _____
Marital Status: _____ Social Security No.: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____
Cell: _____ Email: _____
Preferred Contact Method: ____ Home ____ Work ____ Cell____ Email
Whom may we thank for referring you to our practice?

INSURANCE INFORMATION

Subscriber Last Name: _____ First: _____ MI _____
Birth Date: _____ Is Subscriber a patient? ____ Y ____ N
Subscriber SS No.: _____ Subscriber ID: _____
Subscriber Street Address (if different): _____
City: _____ State: _____ Zip: _____
Subscriber's relationship to patient: ____ Self ____ Spouse ____Child Other _____
Employer's Name: _____ Group No.: _____
Employer's Street Address: _____
City: _____ State: _____ Zip: _____
Insurance Plan Name: _____ Subscriber ID: _____
Insurance Street Address: _____
City: _____ State: _____ Zip: _____
Insurance Phone: _____
Is Patient covered by additional dental insurance? ____ Y ____ N
(If Yes, please complete additional insurance information below)
Dependent Student Status: _____ Name of School: _____
____ Full Time ____ Part Time
Names of other dependents covered under this plan:

ADDITIONAL INSURANCE INFORMATION

Subscriber Last Name: _____ First: _____ MI _____
Birth Date: _____ Is Subscriber a patient? ____ Y ____ N
Subscriber SS No.: _____ Subscriber ID: _____
Subscriber Street Address (if different): _____
City: _____ State: _____ Zip: _____
Subscriber's relationship to patient: ____ Self ____ Spouse ____Child Other _____
Employer's Name: _____ Group No.: _____
Employer's Street Address: _____
City: _____ State: _____ Zip: _____
Insurance Plan Name: _____ Subscriber ID: _____
Insurance Street Address: _____
City: _____ State: _____ Zip: _____
Insurance Phone: _____
Dependent Student Status: _____ Name of School: _____
____ Full Time ____ Part Time
Names of other dependents covered under this plan:

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DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____ Were X-rays taken? ____ Y ____ N

Former Dentist's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Check (√) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

Are you happy with your smile? ____ Y ____ N

If no, please explain: _____

Do you have severe anxiety about dental treatment? ____ Y ____ N

Have you ever had an adverse reaction to dental treatment? ____ Y ____ N

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctors and staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Signature: _____ _____ **Date:** _____

Print Name: _____

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HEALTH HISTORY

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of last exam: _____

Are you currently being treated by a physician? ☐Y ☐N

If yes, please explain: _____

Have you been admitted to a hospital or had emergency care in the past two years? ☐Y ☐N

If yes, please explain: _____

Are you currently taking any medications, including oral contraceptives or aspirin?

☐Y ☐N If yes, please list: _____

Have you had an allergic reaction? ☐Y ☐N

If yes, please list all allergies: _____

Have you ever had Botox or fillers? ☐Y ☐N

Do you or have you used tobacco products? ☐Y ☐N

For how long? _____

Do you consume alcoholic beverages? ☐Y ☐N

How often? _____

Do you have any history of the following diseases or conditions?

☐ Anemia	☐ Fainting	☐ Intellectual Disability
☐ Arthritis	☐Gastrointestinal Disorders	☐ Nutritional Deficiency
☐ Asthma	☐ Hearing Loss	☐ Orthopedic Problems
☐ Autism	☐ Heart Disease	☐ Rheumatic Fever
☐ Bleeding (prolonged)	☐ Heart Murmur	☐ Transfusion of Blood
☐ Brain injury	☐ Hepatitis/Liver Disease	☐ Scoliosis
☐ Cancer: Type _____	☐ Herpes	☐ Sickle Cell Trait/Disease
☐ Cerebral Palsy	☐ High Blood Pressure	☐ Stroke
☐ Cleft Lip/Palate	☐ HIV Infections (AIDS)	☐ Syndrome: Type _____
☐ Diabetes	☐ Jaundice	☐ Thyroid Condition

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctors and staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Signature: _____ _____ **Date:** _____

Print Name: _____

MODERN DENTISTRY
of Shrewsbury

307 Grafton Street, Suite 203
Shrewsbury, MA 01545
Phone: 508-842-8838
Fax: 508-842-6356
office@shrewsburydentist.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I have received a copy of the Notice of Privacy Practices of Modern Dentistry of Shrewsbury. I hereby authorize, as indicated by my signature below, Modern Dentistry of Shrewsbury to use and disclose my identifying health information in unencrypted electronic format when applicable and necessary for any clinical, financial and insurance purpose.

Print Name: _____ **Address:** _____

Signature: _____ **Date:** _____

Please check your preferred means of communication:

- o You may contact me at my home telephone number _____
- o You may contact me on my mobile telephone number _____
- o You may contact me on my work telephone number _____
- o You may send me an email at _____
- o You may leave detailed messages on voicemail of above numbers, regarding x-ray results and/or appointment needs.

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed: _____
2. _____ Date Added/Removed: _____
3. _____ Date Added/Removed: _____
4. _____ Date Added/Removed: _____

*****For Office Use Only:*****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other (Please specify)

  _____
- o Staff Initials _____

MODERN DENTISTRY
of Shrewsbury

FINANCIAL POLICY

Thank you for choosing Modern Dentistry of Shrewsbury for your dental needs. We are committed to providing you with the best possible care. We ask patients to accept and adhere to financial arrangements regarding their dental treatment. **Payment is due at the time services are rendered**, unless other arrangements have been made in advance. Options for payment include:

1. Payment in full at the beginning of treatment by cash or check will be afforded a 5% courtesy on major restorative procedures, i.e. crowns, bridges, implants. When and if we receive payment from your insurance company, it will be returned to you.
2. Payment by **cash or check** of 50% of the **estimated co-pay** at the start of treatment and 50% when the final restoration(s) is placed. This is only an estimate; you are responsible for any balance not paid by your insurance company.
3. We accept MasterCard, Visa, Discover, and Debit cards at the time of service.
4. We offer third party financing through Care Credit. Care Credit offers an interest free line of credit that can be used repeatedly at many dental and medical health facilities.
5. We accept the following in network insurance plans: Altus, BCBS Dental Blue, Cigna Radius, Delta Dental Premier, and Guardian. We accept the following out of network insurance plans: Aetna, MetLife, BCBS Dental Blue Select and Dental Blue PPO and Cigna Core Network.

Please note that returned checks will be charged a service fee of $35, and any appointment cancelled within 48 hours of scheduled time may be subject to a $75 rescheduling fee.

DENTAL INSURANCE

We accept most traditional dental insurance plans, which allow you to choose any dentist you desire. If you are not sure which type of plan you have, we will be happy to call for you and explain your benefits to the best of our ability. Please understand that your dental insurance is a contract between you, your dental insurance company, and your employer. **While we attempt to estimate your dental benefits to the best of our ability, this is an estimate only and any balance or procedures not paid by your insurance are your responsibility**. Additionally, dental insurance does not cover all dental procedures and typically has a yearly maximum which they contribute to your dental needs. This does not indicate that additional treatment is not necessary.

As a courtesy to you, we are happy to complete and submit insurance claim forms to maximize the likelihood of insurance reimbursement. However, our office cannot guarantee a patient's insurance company will pay. Although we are submitting the forms for you, we do not accept responsibility, under any circumstances for the outcome of the transaction. We will work with your insurance company over any unpaid claim to sort out any confusion, which might arise. It will be the responsibility of the patient to handle any "dispute" with an insurance company over any claim.

Most insurance payments are received within 30 days from the time of billing. **If the patient's insurance company has not made payment to our office within 60 days, we require the patient to pay the balance in full,** and then seek reimbursement from the insurance company. When and if the payment is received in our office, you will be reimbursed immediately.