UNITED DENTAL

131 MERRIMACK ST, LOWELL, MA 01852

978-788-9338

Email: UnitedDentalMA@gmail.com Website: www.UnitedDental.net

MEDICAL AND DENTAL HISTORY

First Name: _________________Last Name: _________________ Date of Birth: ____________________

Social Security # __________________

Address: ____________________________ City _________________ State ________ Zip ____________

Home Phone (____)___________________ Cell (____)_______________ Email ____________________

Emergency Contact____

(Name, Phone, Email)

Whom may we thank to referring you to us? ____

Are you having pain or discomfort at this time? Yes No

If yes, what type and where? ____
____

Medical Doctor's Name (PCP): ____

Address: ____ Phone: (____)____________________

Are you now taking any medication, drugs, pills or herbal? Yes No

If yes, please list medications: ____

Are you allergic to or sensitive to any medication or substance? Yes No

If yes, please list: ____

Have you ever been treated for gum disease? Yes No

Are you considered with bad breath, snoring or sleep apnea, grinding or clenching your teeth? Yes No

Do you wear a night guard? Yes No

Would like a whiter smile? Yes No

Would like a straiten teeth? Yes No

Do you use tobacco products (smoke or chew tobacco)? Yes No

Are your teeth sensitive to the following: Sweet Cold Heat Pressure Nothing

Please indicate which of the following you have had or have at present. Check "Yes" or "No" for each item

Condition			Condition			Condition		
Heart (Surgery, Disease, Attack)	Yes	No	Kidney Trouble	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Ulcers	Yes	No	Aids/HIV Position	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	Blood Transfusion	Yes	No
High/Low Blood Pressure	Yes	No	Glaucoma	Yes	No	Hemophilia	Yes	No
Mitra Valve Prolapse	Yes	No	Contact Lenses	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Emphysema	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Chronic Cough	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Arthritis/Rheumatism	Yes	No	Tuberculosis	Yes	No	Neurological Disorders	Yes	No
Cortisone Medicine	Yes	No	Asthma	Yes	No	Epilepsy/Seizures	Yes	No
Swollen Ankles	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Fainting or Dizzy Spells	Yes	No
Stroke	Yes	No	Latex Sensitivity	Yes	No	Nervous Anxious	Yes	No
Diet (Special/Restricted)	Yes	No	Sinus Trouble	Yes	No	Psychiatric/Psychological Care	Yes	No
Artificial Joints (Hip, Knee, etc.)	Yes	No	Radiation Therapy	Yes	No	TMJ	Yes	No
Chemotherapy	Yes	No	Tumors	Yes	No	Hepatitis A, B, C	Yes	No

Do you have or have you had any disease, or condition not listed? Yes No

If yes, please list: ____

Do you take pre-medication for any condition? Yes No

If yes, please specify: ____

Have you had any other serious illnesses, hospitalizations and/or accidents? Yes No

If yes, please specify: ____

For Women Only:

Are you pregnant? Yes No If yes, what month? ____________________

Are you nursing? Yes No

Are you taking birth control pills? Yes No

- **I authorize the dentist to perform diagnostic procedures and treatment as maybe necessary for proper dental care.**
- **I authorize the release of any information concerning my (or my dependent's) healthcare, advice and treatment to another dentist.**
- **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs I am taking in the last week.**

Patient's Signature: ____ **Date:** __________________

Dentist Signature: ____ **Date:** __________________

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Nombre: ______________ Apellido: ______________ Fecha de Nacimiento: ______________

Seguro Social # ______________________

Direccion: __________________________ Ciudad: _____________ Estado: ____________

Codigo Postal: ____________ Telefono: (______)______________________________ (casa o cellular)

Correo Electronico: ____

Contacto de Emergencia: ____

(nombre, telefono, correo electronico)

Nombre del Referido: ____

Siente dolor o incomodidad en este tiempo? Si No

En caso afirmativo, que tipo y adonde? ____

Medico de Atencion Primaria: ____

Direccion: ____________________________________ Telefono: (______)______________________

Esta tomando medicamentos, drogas, pastillas o hierbas? Si No

En caso afirmativo, lista de medicamentos: ____

Es alérgico o sensible a cualquier medicamento o sustancia? Si No

En caso afirmativo, lista de medicamentos: ____

Alguna vez te han tratado por enfermedad de las encías? Si No

Se te considera con mal aliento, ronquidos o apnea del sueño, rechinar o apretar los dientes? Si No

Llevas protector de noche? Si No

Gustaría una sonrisa más blanca? Si No

Gustaría una sonrisa derecho? Si No

utiliza productos de tabaco (fumar o masticar tabaco)? Si No

Siente los dientes sensibles a lo siguiente: dulce frío calor presión nada

Favor de indicar lo siguiente: Tiene, ha tenido, o tiene en el tiempo presente. Verifique "Si" o "No" para cada artículo.

enfermedad venérea… Si No
SIDA/VIH positivo… Si No
problema de tiroides… Si No
lentes de contacto… Si No
hepatitis A,B,C… Si No
cardiopatía congénita… Si No
soplo cardíaco… Si No
hemofilia… Si No
fiebre reumática… Si No
tumores… Si No
diabetes… Si No
glaucoma… Si No
enfisema… Si No
tos crónica… Si No
corazón (cirugía,enfermedad,ataque)… Si No
dolor de pecho… Si No
herpes labial/ampollas de fiebre… Si No
transfusión de sangre… Si No
Prolapso de la válvula mitral… Si No
valvula cardiaca artificial/marcapasos… Si No
enfermedad de célula falciforme… Si No
enfermedad del hígado/ictericia amarilla… Si No
desórdenes neurológicos… Si No
fiebre del heno/alergia/urticaria… Si No
epilepsia o convulsiones… Si No
problemas de sinusitis… Si No
atención siquiátrica/sicológica… Si No
dieta (especial/restringida)… Si No
Articulación temporomandibular (TMJ)… Si No
problemas renales… Si No
úlceras… Si No
fácilmente abollado… Si No
tuberculosis… Si No
asma… Si No
artritis/reumatismo… Si No
medicina cortisona… Si No
tobillos hinchados… Si No
ataque al corazón… Si No
sensibilidad al látex… Si No
desmayos o mareos… Si No
nervioso/ansioso Si No
quimioterapia… Si No
terapia de radiación… Si No
Articulaciones artificiales (cadera,rodilla,etc)… Si No

Tiene o tuvo alguna enfermedad o condicion que no estan enlistado? Si No
En caso afirmativo, por favor liste: ______________________________

Toma medicación previa para cualquier condición? Si No
En caso afirmativo, por favor especifique: ______________________________

Ha tenido alguna otra enfermedad grave, hospitalizaciones y / o accidentes? Si No
En caso afirmativo, por favor especifique: ______________________________

For Women Only

Estas embarazada? Si No
si si, que mes? __________

Estas amamantando (dando el pecho)? Si No

Estas tomando pastillas anticonceptivas? Si No

- **I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAYBE NECESSARY FOR PROPER DENTAL CARE.**
- **AUTORIZO LA PUBLICACIÓN DE CUALQUIER INFORMACIÓN RELATIVA A MI (O MI DEPENDIENTE) CUIDADO DE LA SALUD, ASESORAMIENTO Y TRATAMIENTO PARA OTRO DENTISTA.**
- **He aconsejado con precisión a mi proveedor de cuidado dental mi estado actual de salud y suplementos dietéticos o herbales, medicamentos y / o medicamentos que estoy tomando en la última semana.**

Firma del paciente: ______________________________ Fecha: ______________

Firma del dentista: ______________________________ Fecha: ______________

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: ____ ("patient")

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name: ______________________ DOB: __________ SSN#: ______________

Street Address: ______________________ City: __________ State: _____ Zip: __________

Home Phone: ______________________ Work phone: ______________________

Employer Name: ____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: ______________ Address: ______________ Phone Number: ______________

Name of Insured: ______________ Relationship: ________ ID Number: __________ Group Number: ________

Secondary Insurance:

Secondary Insurance Name: ______________ Address: ______________ Phone Number: ______________

Name of Insured: ______________ Relationship: ________ ID Number: __________ Group Number: ________

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: ______________________________________ Date: ______________

(to be signed even if Patient is also the Responsible Party)