Lewis Wharf Dental Associates

lewiswharfdental.com
Lewis Wharf Bay No 237 | 28 Atlantic Ave. • Boston, MA 02110--3802
contactus@lewiswharfdental.com
(617)227-4831

Contact Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * _____ * ___ _____
Last | First | MI | Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ * _____ _____ ___ _____ _____
Home | Mobile | Work | Ext | Fax | Other

Address: _____ * _____
Address 1 | Address 2

_____ * ___ * _____ *
City | State | Zip Code

Dental Insurance information

Please check all that applies

☐ Primary dental insurance ☐ Secondary dental insurance ☐ No dental insurance

Name of Insured: _____ _____ ___
Last | First | MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 | Address 2

_____ ___ _____
City | State | Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 | Address 2

_____ ___ _____
City | State | Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 | Address 2

_____ ___ _____
City | State | Zip Code

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Response Date: _____

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Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking or chewing)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- ☐ *Premedication
- ☐ Allergies
- ☐ Allergy-betadine
- ☐ Allergy-Iodine
- ☐ Angina
- ☐ aspirin
- ☐ bruise easily
- ☐ Celexa
- ☐ chrones disease
- ☐ Collections
- ☐ Depression
- ☐ doxycycline
- ☐ Excessive Bleeding
- ☐ gluten intolerence
- ☐ Head Injuries
- ☐ hepatectomy
- ☐ High Cholesterol
- ☐ Iodine
- ☐ lamital
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Naproxen
- ☐ On Prozac
- ☐ Other-see pt. note
- ☐ penicillin
- ☐ Radiation Treatment
- ☐ seasonal allergies
- ☐ Sinus Problems
- ☐ sulfa drugs
- ☐ Triple bypass
- ☐ Vancomycin
- ☐ Zyrtec
- ☐ ablation
- ☐ Allergies-aspirin
- ☐ Allergy-Codeine
- ☐ Allergy-Penicillin
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ cephlex
- ☐ Ciprofloxacin
- ☐ COPD
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hard Of Hearing
- ☐ headaches
- ☐ Hepatitis
- ☐ HIV
- ☐ irregular heartbeat
- ☐ latex
- ☐ Local Anes
- ☐ Lyme Disease
- ☐ Minocycline
- ☐ Nervous Disorders
- ☐ On Prozac
- ☐ Oxycodone/Percocet
- ☐ Pregnancy
- ☐ Respiratory Problems
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ sunflower seeds/oils
- ☐ Tuberculosis
- ☐ Vantin
- ☐ Allergies
- ☐ Allergies-sulfa
- ☐ Allergy-e-mycin
- ☐ amoxicillin
- ☐ Arthritis
- ☐ bactrim
- ☐ ceclor
- ☐ Chemotherapy
- ☐ codeine
- ☐ covid positive
- ☐ Diflucan
- ☐ Epinephrine
- ☐ genital herpes
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ herpes
- ☐ hives
- ☐ Jaundice
- ☐ Leukemia
- ☐ Low blood pressure
- ☐ memory loss problems
- ☐ Mold
- ☐ nickel
- ☐ opiods
- ☐ Pacemaker
- ☐ Pt. On Cumiden
- ☐ Rheumatic Fever
- ☐ Septra
- ☐ Stomach Problems
- ☐ Thyroid Problems
- ☐ Tumors
- ☐ Venereal Disease
- ☐ Allergies
- ☐ Allergy Latex
- ☐ Allergy-erythromycin
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Ceftin
- ☐ Chloroquine
- ☐ Cold sores
- ☐ Defibrillator
- ☐ Dizziness
- ☐ Erythromycin
- ☐ Glaucoma
- ☐ HCM
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ hypoglycemia
- ☐ Kidney Disease
- ☐ Levoquin
- ☐ lung disease
- ☐ Mental Disorders
- ☐ Morphine
- ☐ On Coumadin/Plavix
- ☐ Osteoporasis
- ☐ Parkinson's Disease
- ☐ pulmonary embolism
- ☐ Rheumatism
- ☐ shingles
- ☐ Stroke
- ☐ Tonsilitis
- ☐ Ulcers
- ☐ viral meningitis

Do you have any other health issues or allergies?

_____

_____

_____

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (if to a different office)?

_____

_____

What was done on your last dental visit (if to a different office)?

_____

_____

Prior Dentist's name, address, & phone number:

_____

_____

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

Response Date: _____

Lewis Wharf
DENTAL
EST. 1974

Consent to Examination and Treatment

NOTE: You may delete any portion of the following consent and authorization in whole or in part. To do so, cross out these sections that you wish to delete and place your initials in the left margin opposite to the delete portion. If the deleted section interferes with your dental care or conflicts with the policy of this dental practice, a staff member or the dentist will discuss the matter with you.

I consent to have the dentist and staff of Lewis Wharf Dental, located at 237 Lewis Wharf, Boston, MA, perform examination and tests as are necessary, in the opinion of the dentist, to determine my general and oral health.

I understand that information obtained as a result of this examination and of any treatment that follows that examination, may be shared with others for the purpose of completing the examination and treatment and advancing the quality of care provided in this dental office.

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 the 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.

I agree to have the dentists request and to have released to them information regarding my prior health, medical or hospital treatment when such information is essential to the examination and to the treatment that may be proposed.

I also give my consent and permission to the employees and the dentists of this practice to take intra-oral *(inside the mouth)* and extra oral *(outside the mouth)* photographs for educational, research, and communication (laboratory technicians, other dentists and health care providers working on my case) that further improve the quality of oral health care, provided personal identification is protected within reasonable limits.

Lewis Wharf
DENTAL
EST. 1974

1. Treatment to be Provided

I understand that during the course of my treatment the following care may be provided: Examinations , Preventive Services, Restorative Services, Periodontal Services, Endodontic Services, Orthodontic Services, Oral Surgery Services, and Dental Implant Services.

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).

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 mouth 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 after discussing it with me.

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

I understand the conditions stated above and all my questions have been answered.

Date:

Print Name:

Print child's name if under 18:

Parent/ Legal Guardian Name:

Signature:

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