Pondside Dental Associates
793 Centre Street
Jamaica Plain, Mass. 02130
617-522-1970

Patient Health Record

Patient Information

Date:_____

Name:_____Preferred Name _____

Address/City/State/Zip _____

Home Phone_____Business Phone_____Cell Phone_____

Sex: M F Birthdate_____Social Security # _____

Marital Status: Single Married Partnered Separated Divorced Widowed

E-mail Address _____

Employer _____Occupation_____

Notify in case of Emergency_____Home # _____Work #_____

Whom may we thank for referring you? _____

Full Time College Student: Name of College Attending_____

Dental Insurance Information

Insurance Carrier_____

Insurance Address_____

Insurance Phone Number _____

Subscriber _____ Subscriber Social Sec # _____

Subscriber Birthdate_____Relationship to patient_____

Subscriber ID# _____Phone Number_____

Subscriber Employer_____

Medical Health

General Health: Excellent Good Fair Poor

Physician Name _____Physician Phone_____

Date of last visit _____Have you had any operations/serious illnesses?_____

Have you ever had a blood transfusion? Yes No If yes, approximate dates_____

Are you Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Do you have any food or drug allergies? Yes No Please List: _____

Please list all medications, including herbals and vitamins, you are currently taking:

_____

OVER-→

Have you ever been diagnosed with or treated for: (Please circle yes or no for each condition)

Y N Aids/HIV Positive	Y N Hayfever	Y N Pacemaker/Heart Surgery
Y N Anemia	Y N Headaches	Y N Pins/Screws/Plates
Y N Arthritis/Rheumatism	Y N Heart Murmur	Y N Psychiatric Care
Y N Artificial Heart Valves	Y N Heart Conditions	Y N Radiation Treatment
Y N Artificial Joints	Y N Hemophilia	Y N Respiratory Disease
Y N Asthma	Y N Hepatitis	Y N Rheumatic Fever
Y N Cancer	Y N Herpes	Y N Scarlet Fever
Y N Chemical Dependency	Y N Jaundice	Y N High Blood Pressure
Y N Chemotherapy	Y N Kidney Disease	Y N Sinus Trouble
Y N Colitis	Y N Liver Disease	Y N Stroke
Y N Congenital Heart Lesions	Y N Lung Disease	Y N Low Blood Pressure
Y N Persistent Cough	Y N Material/Food Allergies	Y N Surgical Implant
Y N Diabetes	Y N Mitral Valve Prolapse	Y N Thyroid Disease
Y N Epilepsy	Y N Nervous Problems	Y N Tuberculosis
Y N Fainting	Y N Ulcers	Y N Venereal Disease
Y N Glaucoma	Y N Tobacco Habit	Y N Other

Dental History

What would you like done?_____Are you in discomfort?_____

Former dentist_____

Date of last dental care_____Last X-Rays_____

Have you ever had any problems with any of the following: (Please circle yes or no)

Y N Bad Breath	Y N Bleeding/Swollen Gums	Y N Clicking/Popping of Jaw
Y N Grinding/Clenching of Jaw	Y N Loose teeth	Y N Broken Fillings
Y N Sores/Growths in Mouth	Y N Hot Sensitivity	Y N Cold Sensitivity
Y N Sweet Sensitivity	Y N Pressure Sensitivity	Y N Jaw Pain/Tiredness

How often do you brush?_____Floss?_____

What type of brush do you use? Soft Medium Hard Electric

Do your gums bleed while brushing?_____Flossing?_____

Do you chew on one side of your mouth? If so why?_____

Do you wear partials or dentures?_____

Do you gag easily?_____

Are you familiar with the term preventive dentistry?_____

Please add anything you feel may be important

_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature_____**Date**_____

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Notice of Billing Policy

Dear Patient:

Please take a few minutes and review the following billing policies. These policies apply to all of our patients.

1. Payment is due at the time of service. Insurance deductibles are due at the time of service.
2. Payment may be made in cash, personal check or by credit card. If an issued check is returned for any reason, we reserve the right to bill you a service charge of fifteen dollars ($15.00).
3. Insurance: It is your responsibility to understand your particular insurance contract. The insurance contract is between you, your employer and the insurance company. We are not a party to this contract. Not all services provided are covered benefits in all insurance contracts.
   This notice is to advise you of the fact that your dental insurance does not guarantee coverage. This office cannot determine in advance an exact amount of what will be covered. **Payment for the non-insurance portion of your treatment is due at the time of service.**

   Any balance not paid in 90 days from the date of the original bill will be subject to collection and you will be responsible for additional fees as provided by law.

If you have any questions, please see the front desk staff. If you understand and accept the above please sign bellow.

Signature _____ Date _____

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Pondside Dental Associates

793 Centre Street

Jamaica Plain, MA 02130

Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without by written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy right has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____Date: _____

Relationship to patient (if signed by a personal representative of patient):_____