



PATIENT INFORMATION

Dr./Mr./Ms. _____ Home # _____ Work # _____ Cell # _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____

Birthdate ____/____/____ S.S.# ____/____/____ Marital Status _____ Spouse's Name _____

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____ Date of last dental visit _____

Reason for today's visit _____

MEDICAL HISTORY

Physician _____ Dr.'s Phone _____ Date of Last Visit _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING - INDICATE WITH AN (X)

- () Allergies () A.I.D.S./Test positive for H.I.V. () Radiation treatment/Chemotherapy
() Heart disease/Surgery () Venereal disease/Herpes () Cancer
() Rheumatic fever () Hepatitis or liver disorders () Steroid treatment
() Stroke () Kidney disorders () Artificial joints (i.e. hip, knee...)
() Mitral valve prolapse () Diabetes () Gastrointestinal disorders
() Heart murmur () Asthma () Sinus problems
() Anemia or blood disorders () Chronic headaches () Thyroid problems
() Excessive bleeding () Substance abuse () Tuberculosis
() High or low blood pressure () Epilepsy () Seizures
() Arthritis () Psychiatric care () Bulimia/Anorexia
() Neurological disorders () Fainting spells () Pregnancy
() Undiagnosed conditions

PLEASE LIST ANY ALLERGIES TO FOODS OR DRUGS _____

PLEASE LIST ANY MEDICATION YOU TAKE ON A REGULAR BASIS (including birth control pills) _____

PLEASE LIST ANY HOSPITALIZATION IN THE PAST 10 YEARS _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

PRIMARY DENTAL INSURANCE

Insurance Company Name _____ Group Number _____
Subscriber's Name _____ Relation to Patient _____
Employer Name _____ Work Phone _____
Employer Address _____
Subscriber Birthdate ____/____/____ Subscriber S.S.# ____/____/____

SECONDARY DENTAL INSURANCE

Insurance Company Name _____ Group Number _____
Subscriber's Name _____ Relation to Patient _____
Employer Name _____ Work Phone _____
Employer Address _____
Subscriber Birthdate ____/____/____ Subscriber S.S.# ____/____/____

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office on any changes in my medical status. I authorize West Newton Dental Associates, LLP to perform all necessary dental services. I also understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Full payment or full insurance co-payment is due at each appointment. Payment options include:

CASH CHECK VISA /MC AMERICAN EXPRESS DISCOVER CARECREDIT

Signature of Patient _____ Date _____

We at West Newton Dental Associates are proud to be a part of a team whose primary mission is to deliver the finest and comprehensive dental care services today. In order to assist you in your dental care investment, we are providing the following payment options.

Payment Options

1. **Cash** – includes money orders and personal checks.
2. **Visa/Mastercard/American Express/Discover** – we accept credit cards as payment for treatment to the extent of your credit limit permits.
3. **Care Credit** – offers a separate line of credit to cover your entire family’s dental care needs.
 - Care Credit has an interest free option if paid in full within 18 months.
 - There is no annual or membership fee.
 - Down payment is not required.
 - A credit line can be established and approval usually takes less than 10 minutes.
 - Please ask for details.

Due at the time of service

Payment for single visit treatment is due at the time of service. Payment options are listed above. If you have insurance, see below.

Multi-visit treatment

For treatment requiring multiple visits, a down payment of 50% is required at the first visit and then payment in full is due at the completion of treatment. Any anticipated insurance money will be factored into the payment due. Again, payment options are listed above.

Insurance

For those who are fortunate enough to have dental coverage, we will gladly process your insurance claim. We will also *estimate* your deductible and the portion not covered by your insurance. This estimated amount not covered by your insurance is due at the time of treatment and may be paid by any one of the options listed above. Our estimates are subject to final approval by your insurance company: therefore, the amount due to our office is subject to change.

We would be happy to work with you to plan the most appropriate arrangements for your budget. Financing your treatment will allow you to begin your treatment immediately and spread the cost over a period of time. Please remember that the ultimate responsibility for all fees charged, regardless of insurance coverage, is that of the patient or guardian.

Signature of patient/guardian _____ Date _____