DRUMHILL
DENTAL

Welcome To Our Practice

Thank you for scheduling an appointment with *Drum Hill Dental*. It is our goal to prepare you for your initial visit with us, and ensure that your visit is a pleasant one.

What will you need to bring with you?

- Insurance card or proof of insurance
- Completed and signed Medical History and forms provided with welcome packet.
- If under the age of 18, a parent or legal guardian must be present
- Any previous x-rays (within the last year, or 5 years for panoramic or full mouth x-ray). Please have them emailed to us at info@drumhilldental.com .
- Payment: We accept cash, check, major credit/debit cards, and Care Credit.

What is our billing policy?

- We are a "Fee for Service" office, which means that payment is always expected at time of service. If for some reason you are unable to make a full payment on date of service, please speak with our staff at the front desk. We will be happy to estimate all future charges for you.
- If you have dental insurance, will bill your insurance company directly for payment for covered services. If, for some reason, your insurance company does not pay for your visit, you will be responsible for payment. Your deductible and co-pay are expected the day of your appointment, when applicable. We are happy to assist you with questions regarding your dental insurance.
- Please refer to our **Office Policy** form, for details on missed appointment fee's.

****IF YOUR DOCTOR REQUIRES YOU TO BE PRE-MEDICATED FOR DENTAL WORK, PLEASE CALL THE OFFICE PRIOR TO THE APPOINTMENT TO INFORM US.**

Thank you again for choosing Drum Hill Dental. We look forward to meeting you and your family. Please do not hesitate to call our office with any questions.

Sincerely,

Drum Hill Dental

18 Boston Road, Suite 400 ◦ Chelmsford, MA 01824
Tel: (978) 454-5656 Fax: (978) 937-2988
www.drumhilldental.com

DRUMHILL DENTAL

Date: _____

Patient Information

Name _____ Birthdate_____ SS#_____ ☐ Male ☐ Female

Address _____ City_____ State_____ Zip Code _____

Mobile Phone _____ Alternate Phone_____ Email_____

Check Appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Occupation _____ Work Phone _____

Emergency Contact Person _____ Phone _____

Student Status _____ School _____

Person Responsible for account _____ Referred by _____

Dental Insurance

Primary Insurance

Name of Insured _____

Date of Birth _____

Relationship to Patient _____

Insurance Company Name _____

Employer _____

ID/SS# _____ Group# _____

Secondary Insurance

Name of Insured _____

Date of Birth _____

Relationship to Patient _____

Insurance Company Name _____

Employer _____

ID/SS# _____ Group# _____

Dental History

Previous dentist & location _____ Date of last exam _____

How often do you floss? _____ How often do you brush? _____

Please check all that apply:

- □ Bad Breath
- □ Bleeding Gums
- □ Frequent Headaches
- □ Jaw, Head, or neck Injuries
- □ Sensitivity to Hot
- □ Loose Teeth or Broken Fillings
- □ Orthodontic Treatment
- □ Finger Nail Biting
- □ Grinding Teeth
- □ Sensitivity to Cold
- □ Sensitivity to Sweets or Biting
- □ Blisters on Lips or Mouth
- □ Periodontal Treatment
- □ Lip or Cheek Biting
- □ Tooth Pain

→

Health History

Primary Care Physician's Name: _____ Date of last visit: _____

Check the Appropriate Answer:

□ Yes □ No Are you currently under medical treatment? If yes, explain_____

□ Yes □ No Are you taking any medications now? If yes, explain_____

□ Yes □ No Have you had any serious illness or operations? _____

□ Yes □ No Do you smoke or drink alcohol? If yes, how often_____

□ Yes □ No Do you need to pre-medicate for dental procedures? If yes, specify condition_____

□ Yes □ No Do you have any allergies?

□ Local Anesthetics □ Penicillin □ Latex □ Sulfa Drugs □ Aspirin

□ Iodine □ Metals/Jewelry □ Sedative □ Other, please specify: _____

Women Only: Are you Pregnant □ Yes □ No Nursing? □ Yes □ No Taking Birth Control? □ Yes □ No

Please check all that apply:

□ High Blood Pressure	□ Thyroid Problem	□ Chest Pains	□ Rheumatic Fever
□ Frequently Tired	□ Hay Fever Allergies	□ Swollen Ankles	□ Respiratory Problems
□ Stroke	□ Fainting/Seizures	□ Emphysema	□ Epilepsy/Convulsions
□ Asthma	□ Cancer	□ Radiation Therapy	□ Low Blood Pressure
□ Arthritis	□ Glaucoma	□ Tuberculosis	□ Joint Replacement/Implant
□ Recent Weight Loss	□ Leukemia	□ Liver Disease	□ AIDS or HIV Infection
□ Diabetes	□ Hepatitis/Jaundice	□ Anemia	□ Stomach Trouble/Ulcer
□ STD/Herpes Virus/HPV	□Kidney Disease	□ Angina	□ Mitral Valve Prolapse
□ Heart Disease	□ Heart Murmur	□ Heart Attack	□ Cardiac Pacemaker

□ Other _____

*** Please initial if nothing is checked _____**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me or services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance company.

Patient or Guardian Signature _____ Date _____

DRUMHILL
—DENTAL—

OFFICE POLICIES

In an effort to avoid any misunderstandings, we would like to review our financial and office policies before you begin treatment in our office.

Payment is expected at the time services are performed. We accept cash, check and all major credit cards. For extensive services we offer low and **no interest** payment plans through Care Credit.

For our patients with dental benefits our policy is as follows:

You will need to supply us with your dental insurance information (name, date of birth, social security number, employer and ID#). We will do our best to answer any questions you may have about your benefits, but always suggest that you call or visit your insurance company's web site.

We will collect any required estimated co-payment and deductible at each visit. We make every effort to determine your benefits when you receive treatment, but consider your co-payment an **estimate** until we receive payment from your insurance company.

***Please remember that any information we provide relative to your benefits is our best estimate and not a guarantee of the payment that will be received.**

Appointment policy

We reserve appointment times specifically for each patient so that we may provide the ultimate care in service. Please schedule your appointment carefully as **there will be a fee of $40.00/Hygiene, $75/Doctor** to your account for any appointment missed/cancelled without 24 hour notice. Similarly, late arrivals can create scheduling problems with other patients. Please notify us if you are going to be late.

If you need to change an existing appointment, please call during our regular business hours at (978) 454-5656.

If you have any questions about any of our policies, please feel free to ask any member of our staff.

Signature_____ Date_____

Print Name:_____

DRUMHILL DENTAL

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. 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 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.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided: Examinations, Preventative Services, Restorations, Crowns, Bridges, Other Basic and Major Treatment. Patient Initials _____

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). Patient Initials _____

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 teeth 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. Patient Initials _____

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

_____ _____

Patient Signature Date

_____ _____

Parent / Guardian Signature for children under 18 Date

DRUMHILL DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's
(please PRINT name)

Notice of Privacy Practices.

Signature: _____ Date: _____

Release of Information

I, _____, give permission for my dental and/or
(please PRINT name)

account information to be discussed with the following person(s):

Spouse: _____

Parent: _____

Other: _____

Signature: _____ Date: _____

For Office Use Only

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

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

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18 Boston Rd◦ Chelmsford, MA 01824

Tel (978) 454-5656 ◦ Fax (978) 9372988

Email: info@drumhilldental.com

www.drumhilldental.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby request and authorize release of copies of my dental records and x-rays, pertaining to my dental treatment.

From: _____

_____

To: _____

_____

Signature _____

Printed Name _____

Address _____

Date _____