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

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 □ Loose Teeth or Broken Fillings □ Sensitivity to Sweets or Biting

□ Bleeding Gums □ Orthodontic Treatment □ Blisters on Lips or Mouth

□ Frequent Headaches □ Finger Nail Biting □ Periodontal Treatment

□ Jaw, Head, or neck Injuries □ Grinding Teeth □ Lip or Cheek Biting

□ Sensitivity to Hot □ Sensitivity to Cold □ Tooth Pain