Perfect Cosmetic, Family & Sedation Smiles DENTISTRY

Relax. Dentistry's Easy Here.™

Southcoast Smiles

1

PATIENT INFORMATION

Name:	Date of Birth:
Male / Female	Single Married Widowed
Address:	City, State, Zip:
Social Security #:	# of Occupants in Household: Over 18: Under 18:
Employer:	Occupation:
Person to Notify in Emergency:	Phone Number for Emergency Contact:

For appointment confirmations, before/after appointment instructions & other communications:
Cell Phone:
Home Phone:
Work Phone:
Primary Email:

How did you hear about our office?

- ☐ Name: _____ Relationship: _____
- ☐ Community / Charity Event
- ☐ Post Card / Mailer
- ☐ Website / Online
- ☐ Office Sign
- ☐ Other: _____

Dental Insurance:

Name of primary insurance holder: _____
Date of Birth of primary insurance holder: _____
Subscriber ID Number: _____
Dental Insurance Company: _____
Do you have a secondary Dental Insurance? ☐ **Y** ☐ **N**

*Please have Insurance cards ready for our team if you would like a complimentary benefits check.

2 **MEDICAL HISTORY**

A – General Health

1. Physician's name and date of last physical: _____
2. Has there been any changes in your general health during the past year? ☐ **Y** ☐ **N**
3. Are you under a physician's care other than for routine physicals? ☐ **Y** ☐ **N**
4. Have you had any serious illness or operations? ☐ **Y** ☐ **N**
5. Do you bruise easily or have prolonged bleeding? ☐ **Y** ☐ **N**
6. Women: Are you pregnant? ☐ **Y** ☐ **N**
7. Have you ever been hospitalized? Reasons: _____
8. Do you smoke, if so, how much? _____
9. Have you experienced dry mouth and been informed in the past? _____

B – Conditions / Diseases

1. Do you, or have you had:

☐ **Y** ☐ **N**	Anemia or Other Blood Disorders	☐ **Y** ☐ **N**	Immune-suppressed /or HIV positive
☐ **Y** ☐ **N**	Anxiety	☐ **Y** ☐ **N**	Kidney or Bladder Disease
☐ **Y** ☐ **N**	Arthritis	☐ **Y** ☐ **N**	Low Blood Pressure
☐ **Y** ☐ **N**	Artificial Joint / Implants	☐ **Y** ☐ **N**	Material allergies- wood, metals, chemicals, latex
☐ **Y** ☐ **N**	Asthma	☐ **Y** ☐ **N**	Mitral Valve Prolapse
☐ **Y** ☐ **N**	Back Problems	☐ **Y** ☐ **N**	Multiple myeloma or breast cancer
☐ **Y** ☐ **N**	Cancer, Chemotherapy or Radiation	☐ **Y** ☐ **N**	Osteoporosis or Osteopenia
☐ **Y** ☐ **N**	Diabetes	☐ **Y** ☐ **N**	Pacemaker / Heart Surgery
☐ **Y** ☐ **N**	Emphysema	☐ **Y** ☐ **N**	Prolonged fever, coughing blood, or chest pain
☐ **Y** ☐ **N**	Epilepsy	☐ **Y** ☐ **N**	Rapid weight loss of gain
☐ **Y** ☐ **N**	Fainting Spells or Seizures	☐ **Y** ☐ **N**	Rheumatic fever or rheumatic heart disease
☐ **Y** ☐ **N**	Glaucoma	☐ **Y** ☐ **N**	Shingles
☐ **Y** ☐ **N**	Hay Fever	☐ **Y** ☐ **N**	Shortness of breath
☐ **Y** ☐ **N**	Headaches	☐ **Y** ☐ **N**	Sinus trouble
☐ **Y** ☐ **N**	Heart Disease or Heart Trouble	☐ **Y** ☐ **N**	Sjogren Syndrome
☐ **Y** ☐ **N**	Heart Murmur	☐ **Y** ☐ **N**	Thyroid disease / condition
☐ **Y** ☐ **N**	Hepatitis, Jaundice, Liver Disease	☐ **Y** ☐ **N**	Tuberculosis
☐ **Y** ☐ **N**	Herpes	☐ **Y** ☐ **N**	Ulcers / Colitis
☐ **Y** ☐ **N**	High Blood Pressure		

2. Do you have any other conditions not listed that may affect your treatment?

_____

_____

C – Medications

1. Are you taking any medications that may affect your immune system? ☐ **Y** ☐ **N**

2. Are you allergic to or have had any adverse reaction to:

☐ **Y** ☐ **N** Sedatives or tranquilizers	☐ **Y** ☐ **N** Aspirin
☐ **Y** ☐ **N** Antibiotics	☐ **Y** ☐ **N** Codeine or Other Painkillers

Other Allergies: _____

3. Are you using any of the following:

☐ **Y** ☐ **N** Antibiotics or sulfa drugs	☐ **Y** ☐ **N** Insulin or diabetic drugs
☐ **Y** ☐ **N** Anticoagulants (blood thinners)	☐ **Y** ☐ **N** Birth Control Pills
☐ **Y** ☐ **N** High blood pressure medications	☐ **Y** ☐ **N** Steroids (Cortisone, etc.)
☐ **Y** ☐ **N** Heart medications (Digitalis, Inderal, Nitroglycerin)	

Other Medications: _____

4. Have you ever taken any of these medications?

☐ **Y** ☐ **N** Etdronate (Didronel)	☐ **Y** ☐ **N** Ibandronate (Boniva)
☐ **Y** ☐ **N** Tiludronate (Skelid)	☐ **Y** ☐ **N** Pamidronate (Aredia)
☐ **Y** ☐ **N** Alendronate (Fosamax)	☐ **Y** ☐ **N** Zoledronate (Zometa)
☐ **Y** ☐ **N** Ridedronate (Actonel)	

3 DENTAL HISTORY

1. When was your last full mouth dental examination? _____

2. When was your last dental cleaning? _____

3. What are your expectations of todays visit? _____

4. On a scale of 1-10, How apprehensive are you about being at the dentist / dental treatment?
   1 2 3 4 5 6 7 8 9 10

5. Do you like the appearance of your teeth? ☐ **Y** ☐ **N**

   If no, please explain: _____

6. Please answer Yes or No to the following questions:
   - ☐ **Y** ☐ **N** Do you suffer from pain or discomfort with your jaw joints (TMJ)?
   - ☐ **Y** ☐ **N** Do you have any injuries or inflamed areas in your mouth?
   - ☐ **Y** ☐ **N** Have you ever experienced any growths or sore spots in your mouth?
   - ☐ **Y** ☐ **N** Had "Novocaine" anesthetic?
   - ☐ **Y** ☐ **N** Had any reactions or allergic symptoms to "Novocaine"?
     If yes, explain: _____
   - ☐ **Y** ☐ **N** Have you had any serious trouble associated with previous treatment?
     If yes, explain: _____

7. On a scale of 1-10, How would you rate your last dental experience
   1 2 3 4 5 6 7 8 9 10

   How could it have been improved for you? _____

8. Check Yes or No if you have had any difficulties with:

☐ **Y** ☐ **N** Bad Breath	☐ **Y** ☐ **N** Periodontal Treatment
☐ **Y** ☐ **N** Bleeding Gums	☐ **Y** ☐ **N** Sensitivity to Cold
☐ **Y** ☐ **N** Clicking or Popping Jaw	☐ **Y** ☐ **N** Sensitivity to Hot
☐ **Y** ☐ **N** Food Collection Between Teeth	☐ **Y** ☐ **N** Sensitivity to Sweets
☐ **Y** ☐ **N** Grinding or Clenching Teeth	☐ **Y** ☐ **N** Sensitivity When Biting
☐ **Y** ☐ **N** Loose Teeth or Broken Fillings	☐ **Y** ☐ **N** Sores or Growths in Mouth

I hereby certify that the above information is true and in addition authorize David Ahearn, and staff under his direction to perform dental/oral surgical procedures to restore and/or preserve my overall dental/oral health.

_____
Signature Date

4 Appointment Confirmation Policy

We will send you a series of reminders prior to your appointment and ask that you confirm your appointment:

- **First Reminder:** 3 days before your appointment we will contact you and ask that you reply to confirm within 24hrs.
- **Second Reminder:** Sent 2 days prior to your visit, we ask you to confirm by 1pm the next day.
- **Third Reminder:** The day before your appointment, we will attempt to contact you a final time, and ask that you confirm by 1pm that day. If we don't hear from you, we will keep your appointment open if *possible*, but may be forced to give it to an emergency case.

How would you like us to contact you for these Reminders? (You may choose more than one!)

☐ Email ☐ Text ☐ Phone

I have read and agree to the Confirmation Policy. _____
Signature Date

5 Informed Consent

I authorize Southcoast Smiles / Perfect Smiles and/or designated staff to perform any services necessary to diagnose myself or my dependent's dental needs. Upon such diagnosis, I authorize Southcoast Smiles / Perfect Smiles and/or designated staff to perform all recommended treatment mutually agreed upon by me. I understand that the use of anesthetics and sedatives sometimes involves risks, and that I can ask for a complete recital of these risks.

_____

Signature Date

6 HIPAA

Patient Name: _____

Family Name (if applicable): _____

The providers of David J. Ahearn, DDS, PC will, when necessary, refer me to another provider for care.

I give permission to David J. Ahearn, DDS, PC to send any needed information contained in my medical records to that provider.

Initial_____

7 Privacy Practice

I have read and agree to the Notice of Privacy policy provided and have obtained a copy for my records, if requested.

_____

Signature Date

Patient REFUSED to sign – Staff member initials of approval _____

8 Understanding of Warranty

I have read and agree to the Limited Dental Warranty policy provided and obtained a copy for my records.

_____

Signature Date

9 Insurance Policy

I understand that Dr. David Ahearn and Southcoast Smiles / Perfect Smiles will bill my dental insurance for my treatment.

In the case that my insurance company denies the claim, I realize that I am responsible for any and all charges incurred for my treatment.

_____

Signature Date

Perfect Cosmetic, Family & Sedation Smiles DENTISTRY

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Limited Dental Warranty

We stand behind our recommended treatment because we only provide treatment that is long lasting and not a short-term fix. Our treatment plans are developed for prevention.

Our goal is not to simply correct any dental problems you may have, but to help prevent dental disease in the future to save you time and expense. The long-term success of the treatment we provide depends on you: Taking care of your teeth and gums at home and visiting our office for regular professional exams, cleanings and fluoride treatments is imperative (3, 4, or 6 month intervals depending on your condition). No one can perfectly care for their teeth at home alone.

By seeing you on a regular basis, we will better be able to track your treatment and make any needed adjustments quickly, without disrupting your health. **Warranty valid only if you get your regular cleanings at our office.**

TWO YEAR WARRANTY

- ***Composite (Tooth Colored) Fillings*** - If composite is our recommended treatment, we will replace or repair a failed composite at no charge as long as the filling was the recommended treatment.
- ***Dental Sealants*** - We will repair or replace sealants damaged through normal use at no charge.

THREE YEAR WARRANTY

Full upper and lower denture patients must be seen once every 12 months to maintain coverage.

- ***Dentures and Partial Dentures*** - If your denture is damaged under normal use (a tooth chips or breaks, or a flange breaks) we will repair it at no charge. **This does not include accidents, such as dropping your denture.**

FIVE YEAR WARRANTY

- ***Crowns, Bridges, Inlays, Onlays and Porcelain Veneers*** - We will replace or repair these treatments at no charge if they break, are lost, or decay with normal use. **This does not include accidents that could also break normal healthy teeth, such as trauma.** If a night guard is part of your treatment plan, it must be worn every night and brought to every visit.

This warranty does not include anything not mentioned above, including but not limited to: root canal therapy and night guards, nor does it cover damage to teeth or dental prosthesis caused by accident, trauma, neglect or improper use (e.g. biting non-food items, such as ice). Warranty will be voided in the event that the patient does not comply with prescribed treatment, including regular professional exams, cleanings and fluoride treatments (at 3, 4, or 6 month intervals depending on your condition).

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Notice of Privacy Practices

David J. Ahearn DDS PC ♦ Perfect Smiles ♦ Southcoast Smiles

(ASK FOR A COPY)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **The privacy of your health information is important to us.**

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice takes effect 4-14-03 and will remain until replaced by us.

We reserve the right to change our privacy practices and the terms of this Notice at any time, as permitted by laws. Before we make a significant change in our privacy practice, we will change this Notice and make the new Notice available to you upon request. You may request a copy at any time.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment and healthcare options.

Your Authorization

In addition to our use of your health information in connection with our healthcare operations, you may give us written authorization to use your information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it at any time. Unless you give us this authorization, we cannot use or disclose your information, except to those described in this Notice.

Your Family and Friends

You may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Marketing Health Related Services

We will not use your health information for marketing communications without your written authorization.

Required By Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim or other crimes.

National Security

We may disclose to military authorities the health information of Armed Forces Personnel under certain circumstances. We may disclose to authorize officials information required by lawful intelligence, counterintelligence and other national security activities.

Questions or Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your information, you may complain to us using the contact information below. We support your right to the privacy of your information.

Contact Office Manager for Questions ♦ 508-636-6566

302 Village Way, Westport, MA 02790 ♦ 185 Highland Avenue, Seekonk, MA 02771