ATTLEBORO DENTAL

GENERAL & COSMETIC DENTISTRY

SANG BAE, D.M.D.
11 Holbrook Ave
North Attleboro, MA 02760
508-695-5800
Fax- 508-455-3755

DATE________________

PATIENTS NAME________________________________ BIRTH DATE____________________
ADDRESS________________________________ CITY______________ ZIP____________
HOME PHONE________________________________ CELL#____________________
SOCIAL SECURITY #________________________________ OCCUPATION____________________
EMPLOYER________________________________ BUSINESS#____________________
BUSINESS ADDRESS, CITY____
EMERGENCY CONTACT____

SPOUSES NAME________________________________ BIRTH DATE____________________
SPOUSES SOCIAL SECURITY #____
EMPLOYER________________________________ OCCUPATION____________________
BUSINESS ADDRESS, CITY____
BUSINESS PHONE________________________________ CELL #____________________

REFERRING DENTIST____
PHYSICIAN

PERSON RESPONSIBLE FOR ACCOUNT____
PARENTS SIGNATURE (IN CASE OF A MINOR)____

INSURANCE INFORMATION

*PRIMARY DENTAL COMPANY____
SUBSCRIBER ID#________________________________ GROUP#____________________
SUBSCRIBER NAME____
**SECONDARY DENTAL COMPANY____
SUBSCRIBER ID#________________________________ GROUP#____________________
SUBSCRIBER NAME____

UNLESS OTHERWISE ARRANGED, PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE WILL PROCESS PRIVATE INSURANCE CLAIMS FOR YOU; *HOWEVER YOU WILL BE RESPONSIBLE FOR ANY BALANCE THAT YOUR INSURANCE COMPANY HAS NOT PAID WITHIN 30 DAYS OF FILING.*

WE ACCEPT CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS AND DISCOVER...

SIGNATURE________________________________ DATE________________

Attleboro Dental Inc

PATIENT HEALTH UPDATE RECORD

PATIENT NAME: ____ D.O.B. ________________

HOME PHONE:_________________________ ____ CELL PHONE:__________________________ ______

ADDRESS: __________________________ _________CITY:______________ ST: _____ ZIP CODE: __________

GENERAL HEALTH (CHECK ONE): EXCELLENT__ GOOD__ FAIR__ POOR__

MEDICAL DOCTOR/PRIMARY CARE_________________________________ PHONE:_______________

LIST OF MEDICATIONS YOU'RE CURRENTLY TAKING AND REASONS WHY:

____

Have you ever been hospitalized OR ANY SURGERY? NO____ YES____ **for what and date of last visit:**

____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

___PENICILLIN, ___ASPIRIN, ___DENTAL ANESTHETICS, ___TETRACYCLINE, ___ERYTHROMYCIN,

___CODEINE, ___LATEX,___SULFA, OR OTHER IF SO PLEASE LIST: ______________________________

DO YOU NEED TO BE PRE MEDICATED BEFORE SEEING THE DOCTOR TODAY: ___YES ___NO

ARE YOU TAKING BIRTH CONTROL PILLS? YES___ NO___. ARE YOU PREGNANT? YES___ NO___

ARE YOU SUBJECT TO PROLONGED OR ABNORMAL BLEEDING? YES___ NO___

HAVE YOU EVER BEEN TREATED FOR:

___PAIN IN JOINTS	___GLAUCOMA	___DRUG/ALCOHOL ABUSE
___HEART DISEASE	___ HEART ATTACK	___HEART MURMUR
___CONGENITAL HEART DEFECT	___ MITRAL VALVE PROLAPSE	___ ARTIFICIAL HEART VALVE
___ ARTIFICAL JOINTS OR ANY METAL IMPLANTS	___ BLOOD TRANSFUSION	___JAUNDICE
___KIDNEY PROBLEMS	___ ANGINA PECTORIS	___ HIV VIRUS OR AIDS
___HAY FEVER	___SHINGLES	___ ASTHMA OR BRONCHITIS
___ SEVERE HEADACHES/MIGRAINES	___ HIP REPLACEMENT	___ HEMOPHILIA
___ ARTHRITIS	___STROKE	___ HIGH CHOLESTEROL
___ HIGH/LOW BLOOD PRESSURE	___DIABETES	___CANCER
___CHEMOTHERAPY	___RADIATION TREATMENT	___ EMPHYSEMA
___ TUBERCULOSIS OR LUNG DISEASE	___ EPILEPSY	___SEIZURES
___ RHEUMATIC FEVER	___LIVER DISEASE	___ HEPATITIS: A, B, OR C
___HERPES	___SINUS PROBLEMS	___ANEMIA
___FEVER BLISTERS	___ PSYCHIATRIC PROBLEMS	___ULCERS OR COLITIS
___ VENERAL DISEASE		

Others, please explain:

____

____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____________________________ DATE: __________

DENTIST: ____________________ (PRINT NAME) ___________________ DATE: __________

UPDATED ON _______ __PATIENT SIGNATURE _________________ DR SIGNATURE _______________

Attleboro Dental Inc
11 Holbrook Ave, North Attleboro, MA 02760
Phone: 508-695-5800
Fax: 508-455-3755

OUR OFFICE POLICY

GENERAL

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor. CO-PAYS ARE DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMEX and CARE CREDIT.

REGARDING INSURANCE

Fees are estimates only, are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portion and deductibles are due prior to treatment. In the event that YOUR insurance coverage changes to a plan where we are non-participating providers, refer to above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless for any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard/AMEX, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

Unless canceled, within 24 hours prior to the scheduled appointment, a charge of **$50.00** could be applied. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 18% annually as provided by state law. Thank you for understanding the Financial Policy.

CONSENT

I have read, understand, and agree to the Office Policy, and have received a copy of this office's Notice of Privacy Practices.

Signature____ **Date**______________