NEWTON STREET
DENTAL
Comfortable Care, Beautiful Smiles

Hello!

We would like to extend to you a very warm welcome to our dental practice. We are committed to doing everything possible to provide you with high quality dental care and also make your visit to our office as pleasant and comfortable as possible.

The following information will be very useful to you:

- Our practice includes a wide range of dental procedures, including comprehensive dentistry, endodontics (root canals), extractions, dental implants, crowns, and bridges as well as other esthetic and restorative procedures.
- At the time of your first appointment, we will listen closely to your concerns and conduct a thorough, comprehensive examination. We will take the time to give you the personal attention you deserve.
- Before any treatment begins, we will sit down with you and advise you of your options so you can make an informed choice regarding the best course of treatment for your specific needs. We respect our patients, and our goal is to provide you with the highest quality care in an atmosphere of mutual trust.
- We accept most dental insurance plans. Our office provides easy financing for major dental work that insurance may not cover.
- Our practice prides itself on our word-of-mouth referrals. We often treat many members of the same family, and some of our best patients are referred by some of our best patients.

Thank you for choosing our practice to serve your dental needs. If you have any questions, please feel free to call us at (413)538-9604. We look forward to meeting you at your first visit.

Sincerely,
Douglas F. Leigh, DDS

(Please complete the enclosed forms prior to your visit and bring them in with you.)

Newton Street Dental, PC
(413)538-9604
488 Newton Street, Suite 1
(413)534-3533 fax
South Hadley, Massachusetts 01075
admin@newtonstreetdental.com
info@newtonstreetdental.com

HIPAA CONSENT

** You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's

Notice of Privacy Practices.

_____ _____

Signature Date

_____

AUTHORIZATION TO RELEASE INFORMATION

If you wish to grant our staff permission to speak with a friend or family member regarding your private information including billing information, please complete the following. It will be in effect until it is revoked by you or updated with new information, whichever comes first. If left blank, it will be considered a revocation of any previous authorization.

I give permission for the staff of Newton Street Dental to release information to the following people:

Name Relationship to you

_____

_____

_____

Newton Street Dental, P.C.

488 Newton Street, Suite 1
South Hadley, MA 01075
(413)538-9604-phone (413)534-3533-fax
www.newtonstreetdental.com

DENTAL HISTORY

YOUR NAME_____ **DATE**_____

It is important that we know about your dental history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give is confidential and will not be released without your written consent.

Are you having any discomfort now?
_____
Are your teeth sensitive to cold? _____
Heat? _____ sweets? _____ chewing? _____
How long since you last had dental treatment?
_____
What was done then?
_____
_____
Have your teeth been straightened? _____
How often do you brush? _____
How often do you floss? _____
Do you have bleeding gums? _____
Does food wedge between your teeth? _____
Do you every have an unpleasant taste in your
Mouth? _____
Do you grind or clench your teeth? _____
Have you ever had pain in or around your
Ears? _____ your jaw joints? _____
Have you ever had difficulty opening or
Closing your jaw? _____
Do you hear popping, clicking or snapping
Noises when you chew? _____
When you yawn or open wide? _____

Do you have frequent headaches? _____ Earaches? _____
Are you often thirsty? _____ Is your mouth dry? _____
Do you have any nasal obstruction? _____
Are you aware of any lump or swelling in your
mouth? _____
Have you ever had gum treatment? _____
Please list any of your permanent teeth which
have been extracted or lost, and the year that
the tooth was extracted or lost:_____
_____
Are any of your extracted or lost teeth replaced
by a: Fixed bridge? _____ Implant? _____
Removable partial denture? _____
Removable full denture?_____
Have you ever had complications after
extractions? _____
Have you ever had a bad experience in a dental
office? _____
Do you feel nervous about having dental
treatment? _____
Why? _____
Are your teeth important to you? _____
Do you want to keep your natural teeth in health
and comfort for your lifetime? _____

If you have additional information about your dental history that you feel is important, or if you have additional concerns about your dental health, please use the remaining space to explain.
-
_____
_____
_____
_____
_____

TIME 10:27 AM

DATE 7/1/2020

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

conversion updated

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◉ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ◉ No	Cortisone Medidne	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

NEWTON STREET
DENTAL
Comfortable Care, Beautiful Smiles

Notification of the transfer of care and Authorization for Disclosure of Information

Dear Dr. _____

Office Phone # and Location_____

I am transferring my primary dental care to: Newton Street Dental, P.C.

I authorize you to send information concerning your dental findings and treatment while I was under your care. I authorize you to send copies of my most recent radiographic bitewings, panorex, and any other appropriate records at your earliest convenience to:

Newton Street Dental, P.C.
488 Newton Street, Suite 1
South Hadley, MA 01075
info@newtonstreetdental.com

(Please sign for each patient of a family)

Patient's Name (printed)	Patient Signature (Guardian)	Date
Patient's Name (printed)	Patient Signature (Guardian)	Date
Patient's Name (printed)	Patient Signature (Guardian)	Date

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Email Form

Clear Form