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

Newton Street Dental P.C.
488 Newton Street
South Hadley, MA 01075
(413)-538-9604

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

YOUR NAME _____ BIRTH DATE _____ TODAY'S DATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ WORK PHONE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

YOUR EMPLOYER _____ MAY WE CALL YOU AT WORK? _____

MARITAL STATUS _____ SPOUSE _____

SPOUSE EMPLOYED BY _____ WORK PHONE _____

IN CASE OF EMERGENCY, CONTACT _____ THEIR PHONE _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT _____

DENTAL INSURANCE COMPANY (PRIMARY CARRIER) _____ GROUP NO. _____

EMPLOYEE _____ BIRTH DATE _____ UNION LOCAL _____

SUBSCRIBER ID # _____ SOCIAL SECURITY # _____

DENTAL INSURANCE COMPANY (SECONDARY CARRIER) _____ GROUP NO. _____

EMPLOYEE _____ BIRTH DATE _____ UNION LOCAL _____

SUBSCRIBER ID # _____ SOCIAL SECURITY # _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

CONSENT: I hereby authorize this dental office to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors to perform any and all forms of treatment, medication, and therapy, that may be indicated. I authorize and consent that the doctors may choose such assistance as deemed fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

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.
-
_____
_____
_____
_____
_____

HEALTH HISTORY

Although dentists primarily treat the area in and around your mouth, it is important for us to know the facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is strictly confidential.

Patient's name_____ Occupation_____

Address _____Phone #_____ Work #_____

Date of last physical examination: _____ Physician's name: _____ Tel#_____

Have you been under the care of a physician in the past two years? ☐ ☐ YES/NO Have you been hospitalized during that time? ☐ ☐ YES/NO

Are you allergic to (i.e.; itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? YES/NO_____

Have you ever taken prescription Redux or Pondimin (Fen Phen)? ☐ ☐ *****YES/NO_____

Have you ever had excessive bleeding requiring special treatment? ☐ ☐ YES/NO_____

Circle any of the following that you have had or have at the present:

- ☐ Heart Failure
- ☐ Heart Disease/Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ *****Mitral Valve Prolapse
- ☐ *****Heart Murmur
- ☐ *****Rheumatic Fever
- ☐ *****Congenital Heart Lesions
- ☐ Heart Pace Maker
- ☐ Heart Surgery
- ☐ Cancer (Type: _____)
- ☐ Anemia
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Treatment
- ☐ *****Artificial Hip, Knee, or Joint
- ☐ Kidney Disorders
- ☐ Ulcers
- ☐ Use of Tobacco Products
- ☐ Emphysema
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Chronic Cough
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Fainting or Dizzy Spells
- ☐ Sickle Cell Disease
- ☐ Thyroid Disease
- ☐ HIV Positive, ARC, AIDS
- ☐ Alcoholism/Drug Addiction
- ☐ Eating Disorder
- ☐ Glaucoma
- ☐ Cortisone Medicine
- ☐ Hepatitis (Type: _____)
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Blood Transfusion
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Cold Sores
- ☐ Herpes
- ☐ *****Any Type of Implant
- ☐ *****Any Type of Transplant

*Antibiotic medication **<u>may</u>** be required prior to your appointment**.**

*** Have you taken antibiotics prior to dental appointments in the past? YES/NO Which antibiotic? _____**

WOMEN: Are you pregnant? ☐ ☐ YES/NO Are you nursing? ☐ ☐ YES/NO Are you taking birth control pills? ☐ ☐ YES/NO

Please list **<u>all</u>** medications you are currently taking (including over the counter medications, vitamins, or herbal remedies):

_____

Do you have any disease, condition, or problem not listed? YES/NO Please explain _____

_____

To the best of my knowledge, all of the information on both sides of this form is true and correct. If there is any change in my health, or my medications, I will inform the doctor prior to any treatment. I authorize treatment for the person named above and agree to pay all fees and charges for such treatment. I understand that Drs. Leigh and Resnick will use my health history information as necessary for diagnosis or treatment. I understand that antibiotics may reduce the effectiveness of birth control pills.

SIGNATURE: _____ **Date:** _____

I have reviewed my medical history and the above (including any changes) is accurate: Date: _____ Initials: _____

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

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
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