FRAMINGHAM FAMILY DENTAL CARE

PATIENT INFORMATION:

Please Circle:
Single Married Widowed Divorced Separated

First Name M.I. Last Name

Home No. Work No.

Street Address

Cell No. Email

City State Zip Code

Date of Birth SS#

Referred By

PERSON RESPONSIBLE FOR ACCOUNT:

First Name M.I. Last Name

Relationship to Patient

DENTAL INSURANCE INFORMATION:

Primary Insurance		Secondary Insurance	
Employer Name & Address		Employer Name & Address	
Insurance Company Name		Insurance Company Name	
Insurance Company Address		Insurance Company Address	
Subscriber's Name	SS#	Subscriber's Name	SS#
Subscriber's ID No.	Group No.	Subscriber's ID No.	Group No.

PLEASE LIST ALL FAMILY MEMBERS:

PATIENT IN THIS OFFICE:

Family Member	Date of Birth	Patient in this Office
	Date of Birth	
	Date of Birth	
	Date of Birth	
	Date of Birth	

METHOD OF PAYMENT:

Payment is expected at each appointment. As a service to you we will submit your insurance form; however, your co-payment is expected at each appointment. If alternate arrangements are made, I authorize a credit check. FINANCE CHARGE: If I do not pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. THE FINANCE CHARGE will be a periodic rate of 1.5% per month, which is an ANNUAL PERCENTAGE of 18% applied to the last month's balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Patient/Authorized Signature Date

AUTHORIZATION:

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also authorize the release of my x-rays to any other dentist that will be participating in my care. The information on this page and the medical history are correct to the best of my knowledge.

Patient/Authorized Signature Date

Time 10:43 AM

Framingham Family Dental Care, PC

Date 1/26/2018

FFDC 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.

Question		If yes
Are you under a physician's care now? If yes, list name, address and phone number.	○ 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
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	If yes
Do you use tobacco in any form?	○ Yes ○ No	If yes
Are you using any alcohol?	○ 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

Question		If yes
Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis A/B/C	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Herpes	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Blood Transfusion	○ 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	Low Blood Pressure	○ Yes ○ No
Cancer/Tumors	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy/Radiation	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains/Angina	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	STD	○ Yes ○ No	Prosthetic Heart Valve	○ Yes ○ No	Organ Transplant	○ 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:__________

DENTAL X-RAY RELEASE REQUEST

To: ______________________________________

Name of Dentist

Address: ______________________________________

____

City State Zip Code

I hereby authorize the release of my dental x-rays and request that they be transferred to:

Framingham Family Dental Care, P.C.
Adelina Duka, DMD
Arvi Duka, DMD
434 Old Connecticut Path
Framingham, MA 01701
Tel (508) 626-2402
Fax (508) 626-8130
staff@ffdcsmile.com

PLEASE NOTE: WE ACCEPT EMAILED RECORDS AND DIGITAL XRAYS

______________________ ______________________

Print Name of Patient Patient's Date of Birth

______________________ ______________________

Print Name of Patient Patient's Date of Birth

______________________ ______________________

Print Name of Patient Patient's Date of Birth

______________________ ______________________

Authorized Signature Today's Date