

FRAMINGHAM FAMILY DENTAL CARE

PATIENT INFORMATION:

Please Circle:

Single Married Widowed Divorced Separated

First Name	M.I.	Last Name
Street Address		
City	State	Zip Code

Home No.	Work No.
Cell No.	Email
Date of Birth	SS#

Referred By _____

PERSON RESPONSIBLE FOR ACCOUNT:

First Name	M.I.	Last Name
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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:

	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

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.

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

Do you use controlled substances? Yes No If yes _____

Other? If yes _____

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Corticone Medicine <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No
Hepatitis A/B/C <input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No
Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
Cancer/Tumors <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy/Radiation <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains/Angina <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	STD <input type="radio"/> Yes <input type="radio"/> No	Prosthetic Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Organ Transplant <input type="radio"/> Yes <input type="radio"/> 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, 1st Floor,
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