WELCOME

1 ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____
❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 EMERGENCY CONTACT

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

CONTINUE ON BACK

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Lost/Broken Filling(s) ❑ Stained teeth ❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth ❑ Teeth grinding ❑ Locking Jaw ❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums ❑ Ringing in Ears ❑ Bad breath ❑ Active Decay/Cavity(ies)

❑ Other:_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist:_____ (_____) _____
Name Address Phone#

Last Dental exam:____/____/____ Last Dental X-rays:____/____/____ Last Dental Cleaning:____/____/____

Have you had problems with previous dental treatment? If so, explain:_____

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from (EXCELLENT=10) 1-10:_____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile?_____

6 MEDICAL HISTORY & INFORMATION

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ **Vitamins/Supplements** _____
❑ Other(s), please list:_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Heart Attack/Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Disease/Angina	**Y N** Shingles
Y N Lung Disease	**Y N** Thyroid Problems	**Y N** Congenital Heart Defect	**Y N** Cancer/Tumor(s)/Growth(s)	**Y N** Hepatitis
Y N Liver Problems	**Y N** Seizures/Epilepsy	**Y N** Artificial Heart Valves	**Y N** Chemotherapy/Radiation	**Y N** Glaucoma
Y N Blood Disease	**Y N** Venereal Disease	**Y N** Mitral Valve Prolapse	**Y N** X-ray or Cobalt Treatment	**Y N** Arthritis/Gout
Y N Kidney Problems	**Y N** Cosmetic Surgery	**Y N** G.I. Problems/Ulcers	**Y N** Frequent Thirst/Urination	**Y N** Leukemia
Y N Scarlet Fever	**Y N** Dizziness/Fainting	**Y N** Emphysema/Asthma	**Y N** Bleeding Problems/Anemia	**Y N** Chest Pains
Y N Tuberculosis TB	**Y N** Cold/Fever Blisters	**Y N** Diabetes/Hypoglycemia	**Y N** High/Low Blood Pressure	**Y N** Bruise Easily
Y N HIV+/AIDS/ARC	**Y N** Blood Transfusion	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Allergies
Y N Rheumatic Fever	**Y N** Alcohol/Drug Abuse	**Y N** Back/Neck Problems	**Y N** Severe/Frequent Headaches	**Y N** Nervousness
Y N Sinus Problems	**Y N** Eating Disorder	**Y N** Respiratory Problems	**Y N** Jaw Problems TMJ/TMD	**Y N** Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine
❑ Dental Anesthetics ❑ Foods:_____ ❑ Others:_____

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

Please rate your general health from 1-10:_____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long?_____ Are you nursing? ❑ Y ❑ N How many children have you had?_____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature _____ Date____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials _____ Date ____/____/____
Comments

Initials _____ Date ____/____/____
Comments

Initials _____ Date ____/____/____
Comments

TAYLOR STREET DENTAL

41 TAYLOR STREET, 4TH FLOOR
SPRINGFIELD, MA 01103
p: (413) 781-7645 | f: (413) 736-3476
MYGREATSMILE.COM

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be Provided**
   I understand that during my course of treatment that the following care may be provided: Examination - Preventive Services – Restorations (fillings) - Crowns – Bridges – Other
   Patient/Parent/Guardian Initials _____ ←

2. **Drugs and Medications**
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissue; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)
   Patient/Parent/Guardian Initials _____ ←

3. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
   Patient/Parent/Guardian Initials _____ ←

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

_____ ←
Patient Signature (Parent/Guardian, if under 18)

_____ ←
Date

_____ ←
Printed Patient Name

_____ ←
Printed Name of Responsible Party
(if different than patient)

Please see other side →

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Taylor Street Dental Associates PLLC / David I Peck DMD PC Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Printed Name of Patient Printed Name of Responsible Party
(if different than patient)

DENTAL INFORMATION RELEASE

I, _____, give my permission to Taylor Street Dental Associates, PLLC / David I Peck, DMD PC to allow the undersigned to speak with the dentists / dental staff in regards to my medical history, dental care, dental treatment, and my account. This form is valid until I request in writing that it be voided. This is in compliance with HIPAA (Health Insurance Portability and Accountability Act) to protect patient's confidentiality of medical information.

I, _____, give my permission to Taylor Street Dental Associates, PLLC / David I Peck, DMD PC to allow the undersigned to pick up my prescriptions and any other hard copy or electronic records and account information from the office if the need arises. (Photo ID will be required for prescription pick-up.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____ _____

Signature of Patient Date of Birth Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notices of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Please see other side →

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OFFICE POLICIES

The primary goal of Taylor Street Dental is to provide you with the highest quality of dental care utilizing only state of the art equipment and materials. To provide this for you, we have put the following office policies into effect.

FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from our patients for costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

Payment is due at the time service is provided. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for in full at the time services are performed. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available upon request and approved credit. There is a $25 fee assessed on returned checks.

We reserve the right to assess a service charge of 1.5% per month on any unpaid balance exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied.

All collection agency fees or attorney fees incurred because of nonpayment will be added to your account balance.

Fee estimates listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination.

INSURANCE

If you have dental benefits, it is your responsibility to provide us with all pertinent insurance information prior to services being provided. If you are concerned about seeing a dentist who participates with your insurance, it is your responsibility to determine if our dentists are participating providers for your plan. It is also your responsibility to inform us of any change in your insurance coverage. We will submit claims for your treatment in our office to your insurance company, as a courtesy to you. An estimate of the insurance coverage for each dental procedure will be given to you, with the understanding that it is but a guideline from which to work until final payment is received from your insurance company and your exact share of the bill is known. We do require that you pay your “estimated” share of the cost as treatment is rendered.

Upon receipt of the insurance payment, we will reconcile your account, and bill or refund any difference. There are often changes in treatment as it progresses, and should this occur, it would reflect a change in your anticipated estimate. If such changes in treatment do occur, please request an updated estimate from the front desk. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You should then seek reimbursement from your insurance company.

(continued →)

Patients must realize that professional services are rendered to a person, and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We cannot render services on the assumption that the charges will be paid for by an insurance company. It is the patient, or responsible party, who is ultimately responsible for payment of the account. However, we will help in every way that we can by filing your claim, and handling insurance queries, processing follow-ups, lost claims, etc., on your behalf.

APPOINTMENT/RESCHEDULING POLICY

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of 48 ***office*** hours' notice (so that we may make every effort to accommodate other patients). If proper notice is not received, a fee of $50.00 will be charged to your account for every hour, or part thereof, of allotted time cancelled/missed.

RESERVATION DEPOSIT POLICY

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for your treatment, a reservation deposit of half of the fee for treatment for all appointments over 1 hour is required.

TELEPHONE/EMAIL POLICIES

At Taylor Street Dental Associates, we contact our patients by telephone, text message, and/or email for appointment, treatment, accounting, and other reasons. We do ask for your consent to use your cell phone to contact you. You can withdraw your cell phone consent at any time, in writing.

We are here to help…***NO*** question is too small for you to ask us about, whether it be regarding your treatment, insurance, or account. We ask that you call or schedule an appointment to meet with one of our patient care coordinators anytime that you have a question.

Your Taylor Street Dental Team

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OVERVIEW OF OFFICE POLICIES

Please read, initial at all red arrows, and sign at bottom.

- Payment at time of service is expected unless other financial arrangements have been agreed to in advance. **Patient/Parent/Guardian Initials→**_____

- Interest or fees added to a patient's account as a result of returned checks, overdue balances, or fees from a collection agency are the responsibility of the patient (or parent/guardian). **Patient/Parent/Guardian Initials→**_____

- All dental services provided are charged directly to the patient and the patient (or parent/guardian) is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. **Patient/Parent/Guardian Initials→**_____

- Patient "co-payment" amounts calculated for treatment, for patients utilizing dental benefits, are simply an estimate, and only after insurance completes their payment will the exact amount be known for which the patient (or parent/guardian) is personally responsible. **Patient/Parent/Guardian Initials→**_____

- There is a $50.00 per hour of (appointment time) charge for any missed appointments or for cancellations with less than 48 **office** hours' notice. **Patient/Parent/Guardian Initials→**_____

- A reservation deposit of half of the fee for treatment for all appointments over 1 hour is required.

CELL PHONE POLICIES

- *I provide consent to Taylor Street Dental/ David I Peck DMD PC to use my cell phone number to call and/or text regarding appointments.* **Patient/Parent/Guardian Initials→**_____

- *I provide consent to Taylor Street Dental/David I Peck, DMD PC to call using my cell phone regarding treatment, insurance, and my account.* **Patient/Parent/Guardian Initials→**_____

  I understand that I can withdraw my cell phone consent at any time, in writing.

In consideration for the professional services rendered to me by the providers of this office, at the provider's recommendation or at my own request, I agree to pay the value of the service(s) to Taylor Street Dental / David I Peck, DMD PC, at the time services are rendered or per my written financial arrangement with the dental practice.

I have read the above office policies of Taylor Street Dental/David I Peck DMD PC and agree to their content.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Printed Name of Patient Printed Name of Responsible Party
(if different than patient)