



Please Print:

Circle One: Dr/Mr./Mrs./Ms./Miss

First: _____ Last: _____ Nickname: _____
 Date of Birth: _____ Social Security Number: _____ Sex: Male/Female Marital Status: S/M/D/W
 Street: _____ City: _____ State: _____ Zip: _____
 Employer: _____ Occupation: _____
 Home Phone: () - Work Phone: () - Cell Phone: () -
 Email Address : _____ @ _____ May we contact you by email? Yes/No
 Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
 Name of person financially responsible for this account: _____ Relationship: _____

If Patient is a Minor, please fill out the following:

Name of Guardian: _____ Relationship: _____
 Address: _____ Phone: () -
 School: _____ School Address: _____

How Did You Hear About Comfort Dental Weymouth?

Television Brochure Live Nearby Yelp Internet Friend/Relative Other: _____

If referred by a friend/relative, please list name: _____

Insurance Information:

Do you have Dental Insurance? **Yes/No**

If yes, do you have Secondary Insurance? **Yes/No**

Subscriber Name	Subscriber Name
Subscriber SSN:	Subscriber SSN:
Subscriber DOB:	Subscriber SSN:
Patient relationship to Subscriber:	Patient relationship to Subscriber:
Employer Name:	Employer Name:
Employer Phone:	Employer Phone:
Insurance Company:	Insurance Company:
Insurance Group Number:	Insurance Group Number:
Insurance Phone:	Insurance Phone:

Are you interested in our easy, flexible, monthly payment plans? (please circle) Yes/No

I understand that I am financially responsible for any treatment performed, whether or not I have Dental Insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment that my insurance company does not cover.

Signature: _____ **Date:** _____

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED

THE INVESTMENT NECESSARY TO COMPLETE DENTAL TREATMENT IS AN ESTIMATE BASED ON INFORMATION FROM OUR EXAMINATION. SHOULD ADDITIONAL PROBLEMS ARISE AS TREATMENT PROGRESSES, THIS ESTIMATE MAY BE REVISED.

We take your health information very seriously. Before we start your treatment, we require that you complete this form on your medical history as it may affect your dental treatment. Please be advised that all information is confidential.

Patient's Name: _____ Date of Birth: _____
 Reason for today's visit? _____ Are you in pain? _____
 What is your dental anxiety level? (please circle) (least) 1 2 3 4 5 (most)
 Date of last dental visit: _____ Date of last dental x-rays: _____
 Do you have any current dental problems? Yes/No If yes, please explain: _____
 Are you pleased with the appearance of your smile? Yes/No If no, please explain: _____
 Have you had any problems with a previous dentist? Yes/No If yes, please explain: _____

Medical Health

How is your general health? Excellent Good Fair Poor
 Who is your physician? _____ Phone: () -

	Yes	No
Do you now have, or have you ever had, any medical problems?		
Have you ever been hospitalized?		
Are you now, or have you recently been, taking any drugs or medication?		
Are you allergic to any drugs or medicine?		
Do you have any difficulty healing from a cut, wound, or extraction?		
Are you currently, or have you ever been, required to, premedicate before treatment?		
Have you ever been tested for a medical allergy?		

Do you have, or have you ever had, any of the following medical problems?

Yes		No		Yes		No		Yes		No	
Rheumatic Fever				Allergies				Liver Disease			
Heart Murmur				Nervous Disorder				Thyroid Problems			
Heart Disease				Fainting Spells				Sinus Problems			
Angina/ Chest Pain				Diabetes				Skin Disease			
High Blood Pressure				Arthritis				Venereal Disease			
Stroke				Cancer				Herpes			
Anemia/ Blood Disease				Tumors/Growths				A.I.D.S			
Lung Disease				Kidney Disease				Hepatitis			
Asthma				Seizure Disorders				Glaucoma			
Hay Fever				Stomach/Intestinal				WOMEN: Are you Pregnant			

None of the Above

If you answered YES to any of the above, please explain:

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND I GIVE PERMISSION FOR ANY NECESSARY TREATMENT BE COMPLETED.

Signature: _____ Date: _____

Doctor's Notes/Medical History Update:



To Our Patients:

Welcome to our office! We are delighted that you have selected us for your dental health care services. Our office staff will provide you with the finest care.

Payment Policy: Payment is due at the time of service. We accept Mastercard, Visa, Discover, American Express, Care Credit, Checks, Debit Card, and Cash.

All overdue accounts will be assessed an annual 18% finance charge and you will be responsible for any collection service fees. There will be a \$30.00 fee assessed for any checks returned unpaid.

Insurance Policy: Co-payments are due at the time of service. (ie: Your estimated share of costs that your insurance company will not cover. This amount will be due at the time of service).

We are pleased to assist you in processing your dental insurance. However, dental insurance policies are a contract between the patient and the insurance company. Therefore, we request that you keep your account current with us and personally consult your insurance company for services not covered.

Coupon Offerings: Payments and coupons must be presented at time of check-in.

Cancellation Policy: Please be aware that confirmation calls are a courtesy service only. Patients are responsible for their appointments. If you miss an appointment and fail to notify us at least 24 hours in advance, a missed appointment fee of between \$30.00 and \$100.00 will be billed to your account.

Thank you again for selecting us as your Dental HealthCare Provider.

Signature: _____ Date: _____