Advanced Dental Centers
New Patient Information Form

Patient Information

Patient Name: _____ **Date:** _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Cell):** _____ **(Work):** _____ **Best time to call:** _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

Whom can we thank for your referral? _____

*Our office sends out appointment reminders via text and email.
Please include this information to receive these services; you always have the option to opt out at any time.

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ CPAP
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Recreational Drugs
_____
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Thyroid Disorder
☐ Tumors
☐ Ulcers
☐ **Aspirin Allergy**
☐ **Codeine Allergy**
☐ **Penicillin Allergy**
☐ **Sulfa Allergy**
☐ **Local Anesthetic Allergy**
☐ Herbs & Supplements
_____
_____
☐ Blood Transfusion
Date: _____
☐ Bisphosphonate Medication
_____
OTHER:
☐ _____
☐ _____

Please list all medications: _____

Please list all allergies: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other_____

Insurance Plan Name:_____

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 treatment, 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, referral 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.

Treatment to be Provided: I understand that my course of treatment may require multiple examinations or procedures. It could include, but is not limited to, hygienist/dentist examinations, preventive services, periodontal care (gum care), and restorative treatment (fillings), crowns (caps), and implant or bridge treatment (to replace missing teeth).

Drugs and Medications: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

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 initial 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.

Billing: I give permission to Advanced Dental Centers to bill my dental insurance provider for the treatment provided, if applicable.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

ADVANCED DENTAL CENTERS

A leading visionary in Dental Care

Dr. Mohamad Shurbaji, D.M.D. and Associates

Weymouth
527 Main Street Weymouth, MA 02190
Phone: (781)331-1181
Fax: (781) 331-4333

Norwood
125 Central Street Norwood, MA 02062
Phone: (781) 255-1055
Fax: (781) 255-0551

Financial Policy:

Thank you for choosing Advanced Dental Centers as your dental care provider. We are committed to providing you with the best possible care using only the best tools in dentistry today. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

Regarding Payment:

- Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. We also partner with Care Credit, a Healthcare credit card; you can sign up for this at CareCredit.com.
- Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor or treatment coordinator.
- If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.
- The parent or guardian that accompanies the minor/child to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre authorized before the appointment date or previous arrangements have been made.
- Returned checks are subject to a $45.00 fee.

Regarding Insurance:

- Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.
- All insurance co-pays and deductibles must be paid at the time services are rendered.
- All charges you incur are your responsibility regardless of your insurance coverage. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.
- As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by indicating so below.

By signing this document, I understand and agree that if this account is not paid when due and the office should retain a collection company for collection, that I am responsible to pay all costs including reasonable interest, attorney fees and a reasonable collection fee. I also give consent for my account to be discussed with the guarantor/responsibly party attached to my account, even if I am over 18 years of age.

Assignment of Benefits: I authorize the dental benefits otherwise payable to me to be paid directly to Advanced Dental Centers.

Signature of Patient or Responsible Party_____**Date**_____

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Effective July | 2019

Missed and Late Appointment Policy Agreement:

Advanced Dental Centers is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice or fails to appear for an appointment, they prevent another patient from being seen.

We require **48 hour notice** for cancellation or rescheduling of appointments.
Due to high demand for appointments and tight scheduling, patients who arrive **15 minutes** or later to an appointment will not be seen.

Please call our office two days prior to your scheduled appointment to notify us of any changed or cancellations. **To cancel a *Monday* appointment, please call our office by 6:00 p.m. on the *Thursday* prior.** After a patient's second failed appointment, you will be charged $25.00 for the cancelled or missed appointment.

In the case that you have dental insurance though MassHealth, we will notify Mass Health of the failed appointment. Unfortunately, MassHealth may then revoke your insurance coverage if excessive appointments are missed, at their discretion.

Please sign below to consent to these terms.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Date