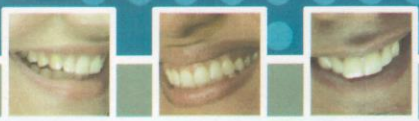
Varinos Dental Associates Of Newburyport
12 Harris Street
Newburyport, MA 01950

(978)462-9303
newburyport@varinosdental.com
www.varinosdental.com



Varinos Dental Associates of Newburyport

WELCOME! Please take a few moments to complete the information below so that we can get to know you better and provide you with the very best dental care. We look forward to serving your dental needs. Thank you.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

☐ I am the patient ☐ I am the parent / guardian ☐ I am the spouse

How would you prefer to be contacted?

_____

If you have any family members who are patients in our office, how are you related?

_____

How did you hear about our office?

_____

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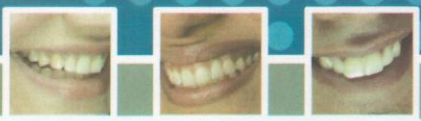

Dental Insurance

If you have dental insurance, please provide us with the following information:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

The Subscriber's Date of Birth and the Primary Insurance ID# or Social Security #:

_____

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

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Secondary Dental Insurance

If you have secondary dental insurance, please provide us with the following information:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

The Secondary Dental Insurance ID # or Social Security #:

_____

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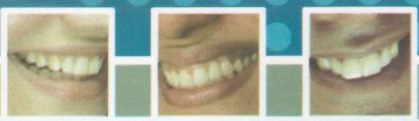

Medical History

Please "check" all of the medical conditions that apply to you. If you indicated "other" please explain.

☐ AIDS / HIV	☐ Allergy-Amoxicillin	☐ Allergy-Erythro
☐ Allergy-N-Saids	☐ Allergy-Sulfa	☐ Anemia
☐ Arthritis	☐ Asthma	☐ Bisphosphonate Meds
☐ Blood Disease	☐ Blood Thinner Meds	☐ Cancer
☐ Codeine Allergy	☐ CPAP Machine	☐ Currently Pregnant
☐ Diabetes	☐ Dilantin Meds	☐ Dry Mouth
☐ Epilepsy	☐ Glaucoma	☐ Hay Fever
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HyperThyroidism	☐ HypoThyroidism
☐ Immunosupressed	☐ Joint Replacement	☐ Kidney Disease
☐ Latex Allergy	☐ Liver Disease	☐ Low Blood Pressure
☐ MEDS-BP	☐ Mental Disorders	☐ Metal Allergy
☐ Migraines / Headache	☐ Mitral Valve Prolaps	☐ Nervous Disorders
☐ NO EPINEPHRINE	☐ OTHER	☐ Pacemaker
☐ Penicillin Allergy	☐ PREMED	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Seizures	☐ Sinus Problems	☐ Smoker
☐ STDs	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers

If you indicated you had a JOINT REPLACEMENT, please tell us the date of the replacement(s):

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ALLERGY to the following medications:

Currently taking the following MEDICATIONS (please include over the counter and all herbal supplements):

If you have been hospitalized within the last 5 years due to a surgery or illness, please explain.

Your Primary Care Physician's name and telephone number:

Please provide the name and location of your pharmacy.

Please provide a name, relationship and telephone number for an emergency contact.

Dental History

If you could change anything about your mouth, teeth, or smile, what would it be?

What is the reason for your dental visit today?

When was your last visit to a dentist?

Here at Varinos Dental Associates of Newburyport we offer Conscious Sedation for those patients who have a fear of going to the dentist. Are you interested in "Sedation Dentistry"?

◯ Yes ◯ No

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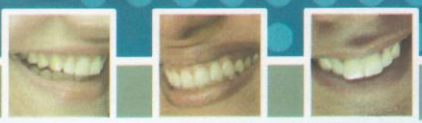

Please take a moment to become familiar with the office policies of Varinos Dental Associates of Newburyport. Place a check in the box once you have reviewed this information. Thank you.

Consent for Treatment

I give permission to Varinos Dental Associates of Newburyport to perform a comprehensive examination necessary to accuartely diagnosis my treatment needs.I certify that my health history information is accurate to the best of my knowledge and it is my responsibility to inform the office of any changes to my health.I authorize Varinos Dental Associates to perform the necessary dental treatment including the advisable local anesthesia. I understand that no dental procedure will be performed without discussing the necessity with me and obtaining my consent to proceed.

Appointment Policy

It is our philosphy to put our patients first and to make your experience a positive one. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.Your appointment is a reservation.We truly appreciate your courtesy of giving us 48 business hours notice if you have a conflict with your appointment and need to reschedule to a different day or time.We will not charge you for your first missed appointment. However, if you miss an appointment a second time within a 12 month span, you may be required to make a deposit when scheduling the next appointment.

Privacy Policy

We are required by federal and state law to maintain the privacy of your information and to offer you a copy of our Privacy Practices. You may request a copy of this Notice of Privacy Practices at any time.

Financial Policy

It is our goal for our patients to understand their treatment needs, as well as, their financial responsibility before treatment. We welcome cash, check, debit cards and any of the major credit cards.We are pleased to offer outside financing through Care Credit. All co-payments are due at the time of scheduling your appointment. As a professional courtesy for our patients with dental insurance benefits, we will submit your claim to your dental insurance company. Please understand that THIS IS ONLY AN ESTIMATE AND NOT A GUARANTEE OF PAYMENT. Any portion not covered by your insurance policy is the responsibility of the patient.

Signature: _____ Date: _____