Varinos Dental Associates

Newburyport – Peabody – Burlington – Winthrop–Haverhill

Welcome! Please take a few minutes 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.

First Name: _________________________________ **Last Name**: ____________________________________ **MI**:_______

Preferred Name:____________________________ **Gender**: ___Male ____Female

Birth Date:___________________ Social Security:________________________ **Family Status**:____Married___Single___Child

Email Address:____

Home Phone:___________________________________ Cell Phone:_________________________________

Address: ____
City:____________________________State:_______Zip:______________

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?_______________________________________

Dental Insurance:

Name of Insured:____

Relationship to Insurance Holder: ______Self _______ Spouse ______Child

Insurance Plan Name: ____

Subscriber Date of Birth:_____________________________________

Primary Insurance ID or Social Security #:____

MEDICAL HISTORY:

PLEASE CHECK ALL THAT APPLY TO YOU. IF YOU INDICATED 'OTHER' PLEASE EXPLAIN AT THE BOTTOM.

Have you had a joint replacement? If yes, when?____

___AIDS/HIV
___Allergy-N-Saids
___Arthritis
___Blood Disease
___Codeine Allergy
___Diabetes
___Epilepsy
___Heart Disease
___High Blood Pressure
___Immunosuppressed
___Latex Allergy
___MEDS-BP
___Migraines/Headaches

___NO Epinephrine
___Penicillin Allergy
___Respiratory Problems
___Seizures
___STD's
___Tuberculosis
___Amoxicillin Allergy
___Sulfa Allergy
___Asthma
___Blood Thinner Meds
___CPAP Machine
___Dilantin Meds
___Glaucoma

___Heart Murmur
___Hyperthyroidism
___Joint Replacement
___Liver Disease
___Mental Disorders
___Mitral Valve Prolapse
___OTHER
___PREMED
___Rheumatic Fever
___Sinus Problems
___Stomach Problems
___Tumors
___Allergy-Erythro

___Anemia
___Bisphosphonate Drugs
___Cancer
___Currently Pregnant
___Dry Mouth
___Hay Fever
___Hepatitis
___Hypothyroidism
___Kidney Disease
___Low Blood Pressure
___Metal Allergy
___Nervous Disorders
___Pacemaker
___Radiation Treatment
___Rheumatism
___Smoker
___Stroke
___Ulcers

OTHER:____
____

Allergy to the following medications:

____
____
____

Currently taking the following medications:

____
____
____

If you have been hospitalized in the last 5 years due to surgery or illness, please explain:

____
____
____

Primary Care Physician's name and telephone number:

____

____

____

Pharmacy Location:

____

____

Emergency Contact:

Name:_______________________________________ Phone Number:____

Relationship to individual:____

____

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

____

What is the reason for your visit today?

____

When was your last visit to a dentist?

____

Are you interested in Sedation Dentistry?

____

Please take a moment to become familiar with the office policies at Varinos Dental Associates. Please check the line, once you have reviewed this information. Thank you.

Consent for Treatment

_____I give permission to Varinos Dental Associates to perform a comprehensive examination necessary to accurately diagnose 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 philosophy to put our patients first and to make sure your experience with us is 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 te major credit cards. We are pleased to offer outside financing through CareCredit. 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 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:____