Boston SMILE center & Laser Dentistry

ALAN SASSON, D.M.D.

PERSONAL INFORMATION

ABOUT YOU

Date ______________________________

Patient Name ______________________________

I prefer to be addressed as ____________________

Date of Birth ______________________________

Social Security No. ______________________________

Please check: ☐ Male ☐ Female

☐ Child ☐ Single

☐ Divorced ☐ Married

☐ Widowed ☐ Domestic Partnered

Home Address ______________________________

City, Zip ______________________________

Cell No. ______________________________

Home No. ______________________________

Work No. ____________________ EXT __________

May we contact you at this work phone? ☐ Yes ☐ No

Email address ______________________________

We send appointment confirmation through email and text. Please select one or both: ☐ Email ☐ Text

If you do not have either, indicate which number to reach you:

____

Employer ______________________________

Occupation ______________________________

Who may we thank for referring you to us?

____

EMERGENCY CONTACT

In the event of an emergency, is there someone you would like us to contact?

Name ______________________________

Relation ______________________________

Phone No. ______________________________

MEETING PATIENT'S IMMEDIATE NEEDS

What brings you here today: ☐ Check-up ☐ Problem

☐ Other (Explain): ______________________________

Why are you changing dental offices?

☐ Insurance ☐ Location ☐ Schedule ☐ Didn't like

☐ Other (Explain): ______________________________

Do you have problems with your teeth now?

☐ Yes ☐ No

If yes, please check: ☐ Hot ☐ Cold ☐ Sweet

☐ Food-Caught ☐ Broken Tooth ☐ Other: ________

____

Would you like to speak in private with the doctor about any problems? ☐ Yes ☐ No

WHAT CONCERNS YOU?

☐ Discomfort ☐ Cost ☐ Time ☐ Inconvenience

☐ Afraid ☐ Other: ______________________________

____

I authorize the release of any information relating to claims filed by **BOSTON SMILE CENTER.**

Signature ______________________________

I wish to assign benefits to **BOSTON SMILE CENTER** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature ______________________________ Date ______________________________

DENTAL INFORMATION

Boston SMILE center & Laser Dentistry

PAST DENTAL HISTORY

When was the last time you saw a dentist?

□ Less than 1 year □ 1 to 2 years □ 3+ Years

Former Dentist ______________________________

Office Location ______________________________

Last Visit Date ______________________________

What treatment did you receive?

□ Check-Up □ Basic Fillings □ Major Dental Work

Was that a comfortable experience? □ Yes □ No

Why? ______________________________

Did you have any treatment that was recommended but not yet completed? □ Yes □ No

If yes, please explain: ______________________________

____

COSMETIC DENTISTRY

Would you like whiter teeth? □ Yes □ No

Is there anything in your smile you would like to change if you could?

□ Color □ Shape □ Position □ Straighter

□ Replace Missing Teeth

□ Other: ______________________________

HOME CARE AND PERIODONTAL HISTORY

What do you do at home to take care of your oral health?

□ Mouthwash □ Brush; how often? ________

□ Floss; how often? __________

Do your gums bleed when you brush and/or floss your teeth? □ Yes □ No

Are you concerned about? □ Bad Breath □ Taste

□ Other; explain: ______________________________

____

ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin	Anesthetics	Novocaine
Metals/Jewelry	Penicillin	Sulfa
Tetracycline	Aspirin	Codeine
Erythromycin	Latex	

Other (explain): ______________________________

____

LIFETIME SMILE PLAN

We will always educate you about the health of your mouth and provide you with treatment options so you can make informed choices. Our mission is to partner with you to ensure a successful plan for attaining and maintaining optimum oral health that will keep you smiling for a lifetime.

DO YOU HAVE ANY QUESTIONS FOR THE DOCTOR ?

____

____

____

____

____

____

____

HEALTH INFORMATION

Boston SMILE center & Laser Dentistry

HEALTH HISTORY

Today's Date ______________________

Patient Name ______________________

Patient's Date of Birth ______________________

Personal Physicians Name ______________________

Office Location ______________________

Phone No. ______________________

Please list any serious illness that you have been hospitalized for in the last 5years: ______________________

____

____

____

Please list all the medications you are currently taking (include over-the-counter medications):

Medication	Reason
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

Are your taking birth control pills? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

Have you taken osteoporosis treatment drugs? ☐ Yes ☐ No

Have you ever or are you taking blood thinners?
☐ Yes ☐ No

Are you taking any supplements? ☐ Yes ☐ No

PRE-MEDICATIONS

Antibiotic pre-medication may be necessary if you have had or currently have the following: (Please circle)

1. Prosthetic cardiac valve
2. Previous bout of infective bacterial endocarditis
3. Cardiac transplant patients who have had valvulitis
4. Congenital heart disease excluding mitral valve prolapse
5. Joint replacements

If you require pre-medication, please indicate what medicine you take? ______________________

HEALTH CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions:

HIV / AIDS	Cold Sores / Herpes
Acid Reflux	Headaches (Severe, Frequent)
Migraines	Hemophilia
Diabetes	Snoring / Sleep Apnea
Smoking / Tobacco	Drug / Alcohol Abuse
Difficulty Breathing	Angina
Arthritis	Artificial Heart Valves
Hips or Joints	Asthma / Hay Fever
Blood Transfusions	Cancer / Chemotherapy
Congenital Heart Defect	Emphysema
Gastrointestinal Disorder	Surgeries
Glaucoma (Narrow Angle)	Hearing-Impaired
Heart Attack	Heart Murmur
Heart Surgery	Anemia
Hepatitis A B C D	High / Low Blood Pressure
Liver Disease	Kidney Problems
Mitral Valve	Prolapse
Pacemaker	Radiation Treatments
Stroke	Shingles
Sinus Problems	Thyroid Problems
Tuberculosis	Tumor Growth
Ulcers	Venereal Disease

Rheumatic / Scarlet Fever

Alzheimer's / Memory Loss

Stents Placed in Heart (Date ______________)

Epilepsy/ seizures/Fainting (Date last episode: (________)

Other (s): ______________________

I hereby certify that the information I have given here today is correct to the best of my knowledge.

Signature ______________________

Date ______________________

BOSTON SMILE CENTER CONSENTS

Boston SMILE center & Laser Dentistry

CONSENT FOR DENTAL TREATMENT

1. I authorize the doctor or designated staff to take x-rays and/or use any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of my dental condition and needs.
2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.
4. I agree to have BOSTON SMILE CENTER share my dental and medical information with other specialists as necessary for my treatment.
5. I agree to keep my reserved dental appointments. If I must cancel an appointment, I agree to give at least 2 business days notice or a cancellation charge may apply.

Signature ____________________ Date ____________________

CONSENT FOR USE OF PHOTOS

In consideration of One Cent of a Dollar ($0.01), receipt of which is acknowledged, I do hereby give BOSTON SMILE CENTER- Alan Sasson, D.M.D. the irrevocable right to use my name, pictures, portraits or photograph in all forms and media and all manners for advertising, trade, or other lawful purpose, and waive any right to inspect or approve the finished product, including written copy, that may be created therewith. I am of legal age.

In signing on behalf of a minor, or myself, I have the legal authority to execute the above release. I have read this release and I consent to its terms.

Signature ____________________ Date ____________________

FINANCIAL DISCLAIMER

I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers' compensation and the like. I also agree to pay for services at the time they are rendered unless other arrangements have been made with the financial coordinator in advance. I understand that financial charges may be added to my account for delinquent payments. I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with J. Alan Sasson, D.M.D., his associates or assistants and that I understand the information provided.

Signature ____________________ Date ____________________