# Dr. Thomas P. Rafferty, D.D.S, LLC

495 Cabot Street | Suite 301 • Beverly, MA 01915 (978)777-1670

**Welcome to our Practice**

**Chart#:** _____

FOR OFFICE USE ONLY

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

_____ Preferred Name

**Title:** **Gender:** _____ Mr/Ms/Mrs/etc ◯ Male ◯ Female

**Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

**Birth Date:** _____

**SS#:** ___-__-____

**Prev. Visit:** _____

**Email Address:** _____

**Best time to call:** _____

**Phone:** _____ Home _____ Mobile _____ Work _____ Ext

_____ Fax _____ Other

**Address:** _____ Address 1

_____ Address 2

_____ City _____ State _____-____ Zip Code

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:** _____

**Phone:** _____

**Employer Address:** _____ Address 1

_____ Address 2

_____ City

_____ State _____-____ Zip Code

Whom may we thank for referring you to our practice?

_____

**In an emergency who should be notified? Please enter Name and Phone number below:**

_____

_____

**Primary Dental Insurance:**

**Name of Insured:**

Last

First MI

**Insured's Birth Date:**

**ID #:** **Group #:**

**Insured's Address:**

Address 1

Address 2

City

State Zip Code

**Insured's Employer Name:**

**Employer Address:**

Address 1

Address 2

City

State Zip Code

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

**Insurance Plan Name:**

**Insurance Address:**

Address 1

Address 2

City

State Zip Code

**Insurance Authorization:**

☐ **By checking this box,**
**I authorize my insurance to pay my benefits directly to the dentist for all services rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges, whether or not paid by insurance.**

**Secondary Dental Insurance**

**Name of Insured:**

Last

First MI

**Insured's Birth Date:**

**ID #:** **Group #:**

**Insured's Address:**

Address 1

Address 2

City

State Zip Code

**Insured's Employer Name:**

**Employer Address:**

Address 1

Address 2

City

State Zip Code

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

**Insurance Plan Name:**

**Insurance Address:**

Address 1

Address 2

City

State Zip Code

**Insurance Authorization:**

☐ **By checking this box,**
**I authorize my insurance to pay my benefits directly to the dentist for all services rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges, whether or not paid by insurance.**

## Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Acetazolamide
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy -Amoxicillan
- ☐ Allergy- Ampicillin
- ☐ Allergy- Epi
- ☐ Allergy- Erythromyci
- ☐ Allergy- Levaquin
- ☐ Allergy- Lisinopril
- ☐ Allergy-Kelfex
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Blood Disease
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Clindamycin
- ☐ COPD
- ☐ Demerol
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hip Replacement
- ☐ HIV
- ☐ Hydroxyzinem
- ☐ Iodine
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Knee Replacement
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Nsaids
- ☐ Other
- ☐ Pacemaker
- ☐ Parkinsons
- ☐ Percodan
- ☐ Propranolol
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tetracycline
- ☐ Thyroid Condition
- ☐ Tinnitus
- ☐ trigeminal neuralgia
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Tylenol
- ☐ Ulcers

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

**If any condition or alerts selected above needs further clarification, please explain below:**

_____

_____

**Do you take antibiotic premedication for your dental visits? If yes, please explain.**

_____

_____

**Name of physician and their specialty:**

_____

_____

**Most recent physical exam and purpose:**

_____

_____

**Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:**

_____

_____

**List all medications, supplements, and/or vitamins taken within the last two years:**

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☐ * **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

## Dental Information

**How would you rate the condition of your mouth?**

☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Previous Dentist name and how long you have been a patient there:**

_____

_____

**Date of most recent dental exam:** _____

**Date of most recent dental x-rays:** _____

**I routinely see my dentist every:**

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**What is your immediate concern?**

_____

_____

**Personal History, Check all that apply:**

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

**If any of the checked boxes need further explanation, please describe:**

_____

_____

_____

_____

## Dental Practice Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

☐ * **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.**

## Notice of Privacy Practices Acknowledgment.

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

☐ **By checking this box, I acknowledge that I have received a copy of the dental practice's Notice of Privacy Practices.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ _____

**Date**

**Name and relationship to patient:**

_____

_____

_____

**Response Date:** _____