Alpha Plus™ DENTAL CENTER

185 HARVARD ST, BROOKLINE, MA 02446
(617) 277-6360
Email: info@alphaplusdental.com **Website**: www.alphaplusdental.com

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: _____ Home Phone: _____

Email: _____

Preferred Contact Method: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

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Medical and Dental History

Last Name: First Name: Birthdate:

Name of Physician: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

	Y	N		Y	N		Y	N
Anesthetic	☐	☐	Iodine	☐	☐	Ibuprofen	☐	☐
Aspirin	☐	☐	Latex	☐	☐	Sulfa	☐	☐
Codeine	☐	☐	Penicillin	☐	☐	If other please list	☐	☐

_____

Do you have any of the following medical conditions?

	Y	N		Y	N
Cancer	☐	☐	Kidney Disease	☐	☐
Radiation/Chemo Therapy	☐	☐	Liver Disease	☐	☐
Artificial Heart Valve/Pacemaker	☐	☐	Arthritis/Rheumatism	☐	☐
Stroke	☐	☐	Psychiatric Care	☐	☐
Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Congenital Heart Disease	☐	☐	Asthma	☐	☐
Abnormal Blood Pressure	☐	☐	Ulcers	☐	☐
Heart (Surgery, Disease, Attack)	☐	☐	Rheumatic Fever	☐	☐
Venereal Disease/HIV	☐	☐	Cold Sores/Fever Blisters	☐	☐
Hepatitis A,B,C	☐	☐	Cortizon Medicine	☐	☐
Glaucoma	☐	☐	Bruise Easily	☐	☐
Thyroid Problems	☐	☐	Diabetes	☐	☐
Joint Replacement(Hip, Knee, etc)	☐	☐	TMJ	☐	☐
Fainting or Dizzy Spells	☐	☐	Nervous/Anxious	☐	☐
Hay Fever/Allergy/Hives	☐	☐	Tuberculosis /Lung disease	☐	☐
Epilepsy or Seizures	☐	☐	Neurological Disorders	☐	☐
Sickle Cell Disease	☐	☐	Chronic Cough	☐	☐

If any other condition please check yes and list ☐ ☐

_____

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Medical and Dental History

	Y	N
Have you ever been treated for gum disease?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do you wear a night guard?	☐	☐
Would you like a whiter smile?	☐	☐
Would you like to straighten teeth?	☐	☐
Do you use tobacco products (smoke or chew tobacco)?	☐	☐
Are you considered with bad breath, snoring, or sleep apnea?	☐	☐
FOR WOMENS ONLY:		
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Are your teeth sensitive to the following: ☐ Cold ☐ Sweet ☐ Heat ☐ Pressure ☐ Nothing

Do you take pre-medication for any condition? If Yes, List below

_____

Have you had any other serious illnesses, hospitalizations and/or accidents? If Yes describe below

_____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of a former dentist _____ City/State _____

Date of last cleaning and exam _____

☐ By Signing below :

-I authorize the dentist to perform diagnostic procedures and treatment as maybe necessary for proper dental care.
-I authorize the release of any information concerning my (or my dependent's) healthcare, advice and treatment to another dentist.
-I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs I am taking.

X_____

Patient/Guardian SIgnature

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Acknowledgement of Receipt Notice of Privacy Policies and Consent Form

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in our HIPAA Notice of Privacy Practice, that we encourage you to read it in full at:

https://www.alphaplusdentalcenter.com/privacy-policy/ before Signing this Consent.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Alpha Plus Dental Center to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third-party payers, i.e., my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.
- I have also been informed of and given the right to review and secure a copy of your HIPAA Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA.
- I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice.
- I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
- I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Additionally, I authorize Alpha Plus Dental Center to share all my protected health information with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ By signing below, I acknowledge that I received and agree to all the provisions of current Alpha Plus Dental Center Notice of Privacy policy.

First Name: _____ Last Name: _____ DOB _____

Relationship to the Patient: _____

X _____

Patient name/Patient representative Signature Date:

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FINANCIAL POLICY

07/22/1966Welcome to Alpha Plus Dental Center. We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best care for our patients.

The following is a statement of our financial policy which we require that you read and sign before your first treatment: Please read carefully and check "I Agree" under this Agreement and sign below.

This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality dental care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. I understand that Alpha Plus Dental Center will collect all co-payments at the time of the visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your Insurance policy, and agreement between your insurance company and Alpha Plus Dental Center.

2. I understand that some or perhaps all of the services provided by Alpha Plus Dental Center may or may not be covered by Dental Benefits. Any uncovered services are my responsibility and full payment is DUE AT THE TIME OF SERVICE unless other arrangements are made.

3. I Authorize Alpha Plus Dental Center to release my information to my insurance company, and receive payment directly from them.

4. I understand that outstanding balances on my account not settled within 30 days of service, will be assessed with a 1.5% service charge. In addition, if my accounts are not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

5. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for the payment of this fee and the amount of the returned check.

6. I understand that if I am unable to make a scheduled appointment, I need to contact Alpha Plus Dental Center at least 48 hours before my scheduled appointment time. Due to the high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $100 FEE WILL BE CHARGED TO MY ACCOUNT FOR ALL MISSED APPOINTMENTS

7. I understand that the dental benefits policy is a contract between me and my insurance company. As a courtesy to me, Alpha Plus Dental Center will provide certain services to help me to understand the cost of the Treatment Plan needed, such as a pre-treatment estimate. If I have any questions concerning the pre-treatment estimate and/or service fees, it is my responsibility to contact my insurance company and clarify all questions before treatment, to minimize any confusion on my behalf.
ULTIMATELY, IT IS UP TO ME TO KNOW MY DENTAL BENEFITS

☐ By signing below, I acknowledge I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the Alpha Plus Dental Center clinicians.

First Name: _____ Last Name: _____ DOB: _____

X_____
Patient/Parent(if minor) Signature: Date: 11/03/2021

Dental Patient Screening Form

Patient Name: (First) _____ (Last) _____ **Birthdate:** _____

	Pre-Appointment Self-Assessment Date:	**OFFICE USE ONLY** Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? **Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.**	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

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Patient Photo Release Form

This form seeks consent for photographs and video to be taken by the Alpha Plus Dental Team.

By signing this form, the patient affirms in understanding that the images and video may be used for different purposes indicated hereunder.

By consenting to the release of images, you agree that you will not receive any form of compensation in cash or any kind.

You likewise understand that your name will not be included in the images. Nonetheless, it is still possible that someone may still recognize you.

Your refusal to consent to the release of your photographs will not, in any way affect the medical care you will receive.

Your decision to allow the utilization of your images is strictly voluntary and consent may be rescinded at any time in writting.

☐ I Authorize
The use of Photographs for the following:

-- Educational Purposes such as Medical Procedure Demonstration
-- Social Media and Online Publishing ads
-- Print Marketing Advertisements
-- Video and Television Media Advertisements

☐ I Decline the option to use my Photographs for marketing purposes.

By signing this form below, I acknowledge that I was explained my rights and responcibilities in regads to photos and videos taking at Alpha Plus Dental Center

First Name: _____ Last Name: _____ DOB _____

X _____ Date: 11/03/2021
Patient name/Patient representative Signature