PATIENT INFORMATION

Patient Name _____ Sex: M / F Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Patient/Parent Cell Phone _____ Work Phone _____

Email _____ **Circle Appropriate** Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time ___ Part Time ___

IF PATINET IS A MINOR:
Circle Appropriate Parents Marital Status Single Married Divorced Widowed Separated

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Employer _____ City/State _____ Birthdate _____ SS# _____

Is this Person Currently a Patient in Our Office? ___ Yes ___ No

Spouse or Parent/Guardian Name _____ Employer _____ Work Phone _____

Cell Phone _____ SS# _____ Birthdate _____

Person to Contact in Case of Emergency _____ Phone _____ Whom May We Thank For Referring You? _____

Insurance Information (PLEASE PROVIDE OFFICE WITH COPY OF INSURANCE CARD

For your convenience, we offer the following methods of payment. Please check the option you prefer. **Payment in full at each appointment.**
Circle Appropriate: Cash VISA Master Card Care Credit Citi-Card Discover American Express

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. 48 hour notice required for cancellations to avoid a charge.**

X_____ Date_____
Signature of patient (or parent/guardian if minor)

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Epilepsy	___Yes ___No	Respiratory Disease	___Yes ___No
Anemia	___Yes ___No	Fainting or Dizziness	___Yes ___No	Rheumatic Fever	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Glaucoma	___Yes ___No	Scarlet Fever	___Yes ___No
Artificial Heart Valve	___Yes ___No	Headaches	___Yes ___No	Shortness of Breath	___Yes ___No
Artificial Joints/Implants	___Yes ___No	Heart Murmur	___Yes ___No	Sinus Trouble	___Yes ___No
Asthma	___Yes ___No	Heart Problems	___Yes ___No	Skin Rash	___Yes ___No
Back Problems	___Yes ___No				
Bacterial Endocarditis	___Yes ___No	Hepatitis Type_____	___Yes ___No	Special Diet	___Yes ___No
Bleeding abnormally, with Extractions or Surgery	___Yes ___No	Herpes	___Yes ___No	Stroke	___Yes ___No
		High Blood Pressure	___Yes ___No	Swollen Feet or Ankles	___Yes ___No
Blood Disease	___Yes ___No	Jaundice	___Yes ___No	Swollen Neck Glands	___Yes ___No
Cancer	___Yes ___No	Jaw Pain	___Yes ___No	Thyroid Problems	___Yes ___No
Chemical Dependency	___Yes ___No	Kidney Disease	___Yes ___No	Tonsillitis	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No	Tuberculosis	___Yes ___No
Circulatory Problems	___Yes ___No	Low Blood Pressure	___Yes ___No	Tumor or growth on	___Yes ___No
Congenital Heart Lesions	___Yes ___No	Mitral Valve Prolapse	___Yes ___No	head or neck	
Cortisone Treatments	___Yes ___No	Nervous Problems	___Yes ___No	Ulcer	___Yes ___No
Cough, persistent or bloody	___Yes ___No	Pacemaker	___Yes ___No	Venereal Disease	___Yes ___No
Diabetes	___Yes ___No	Psychiatric Care	___Yes ___No	Weight Loss, unexplained	___Yes ___No
Emphysema	___Yes ___No	Radiation Treatment	___Yes ___No	Other_____	___Yes ___No
Do you wear contact lenses?	___Yes ___No	Do you smoke	___Yes ___No	Do you consume alcohol	___Yes ___No
Women:					
Are you pregnant?	___Yes ___No	Due Date_____		Are you nursing	___Yes ___No
Taking birth control pills?	___Yes ___No				

Do you take any Bisphosphat medications such as Fosamax or Actonel Boniva ? ___Yes ___No

MEDICATION ALLERGIES

___Yes ___No Aspirin	___Yes ___No Local Anesthetic		_____
___Yes ___No Penicillin	___Yes ___No Codeine		_____
___Yes ___No Sulfa	___Yes ___No Iodine		_____
___Yes ___No Latex	___Yes ___No Milk		_____
___Yes ___No Barbiturates (sleeping Pills)	Other Antibiotics_____		_____

PLEASE LIST CURRENT MEDICATIONS OR SURGERIES

Dental Information Place a mark on "Yes" or "No to indicate if you have had any of the following

Reason for today's visit

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

How often do you floss? _____

How often do you brush_____

Bad breath	___Yes ___No	Jaw pain or tiredness	___Yes ___No
Bleeding gums	___Yes ___No	Lip or cheek biting	___Yes ___No
Blisters on lips or mouth	___Yes ___No	Loose teeth	___Yes ___No
Broken fillings	___Yes ___No	Mouth breathing	___Yes ___No
Burning sensation on tongue	___Yes ___No	Mouth Pain, brushing	___Yes ___No
Chew on one side of mouth	___Yes ___No	Orthodontic treatment	___Yes ___No
Cigarette, pipe, or cigar smoking	___Yes ___No	Pain around ear	___Yes ___No
Clicking or popping Jaw	___Yes ___No	Periodontal treatment	___Yes ___No
Dry mouth	___Yes ___No	Sensitivity to cold	___Yes ___No
Fingernail biting	___Yes ___No	Sensitivity to heat	___Yes ___No
Food collection between teeth	___Yes ___No	Sensitivity to sweets	___Yes ___No
Foreign objects	___Yes ___No	Sensitivity to biting	___Yes ___No
Grinding teeth	___Yes ___No	Sores or growth in mouth	___Yes ___No
Gums swollen or tender	___Yes ___No	Snore	___Yes ___No
		Other _____	

Doctor Signature_____

GENERAL POLICIES – HIPAA

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment and authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other healthcare facilities in the future.

Last Name: _____ First Name: _____ DOB: _____

Legal Guardian (if applicable): _____ Signature: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION / EMERGENCY CONTACTS:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____ Date of Last Visit: _____

Cardiologist: _____ Phone: _____ Date of Last Visit: _____

Heart Problems: _____

Orthopedic Surgeon: _____ Phone: _____ Date of Last Visit: _____

Artificial Joints or Implants: _____

Pharmacy: _____ Phone: _____

I authorize contact from this office to confirm my appointments, treatment, and billing information and information about my health be conveyed via: **(Circle Y/N or All of the Above)**

Y / N CELL PHONE Y / N TEXT TO MY CELL Y / N EMAIL Y / N HOME & WORK ALL OF THE ABOVE

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third-party remuneration from these affiliated companies. We, under the HIPAA Omnibus Rules, provide you with this information with your knowledge and consent.

DENTAL INSURANCE POLICY

Please be aware that your dental insurance is a **contract between you and your insurance company.** Our office provides services to our patients — not to insurance companies. Our priority is always your **oral health** and your **most confident, beautiful smile!**

It is your responsibility to **understand your insurance policy,** including covered services, limitations, deductibles, co-pay requirements, annual maximums, and whether pre-approvals are required. Failure to understand these details may result in additional costs to you.

Payment for services is due at the time of your appointment.

We accept payments from all major dental insurance plans; however, we may not be an in-network provider for your specific plan. Any insurance plan may be subject to a co-pay.

As a courtesy to our patients, we will submit insurance claims to any dental insurance company. Please note that we are in-network only with the following plans:

- **Delta Dental Premier**
- **Blue Cross Blue Shield of Massachusetts Dental Blue**
- **Cigna (Please note: some Cigna plans may still be considered out-of-network)**

Please remember that **insurance estimates are not a guarantee of payment.** Many insurance companies exclude certain procedures or downgrade benefits to a lower reimbursement level. While we make every effort to obtain accurate and up-to-date coverage information, we cannot guarantee coverage — even with formal pre-estimates.

PAYMENTS

- **Patient portion or co-pay is due at the time services are rendered.**
- **If insurance payment is not received within 60 days,** the remaining balance will become the patient's responsibility.
- **Payment Options:** Financing is available through CareCredit. We also accept all major credit cards —---------- **Visa, MasterCard, Discover, and American Express.**

MINORS

- **Minors must be accompanied by a parent or legal guardian for all appointments.**
- If parents are **separated or divorced,** the **parent/guardian accompanying the minor** is responsible for any **co-payments** or **fees** due at the time of service.
- If a minor will attend an appointment **without a parent or legal guardian present,** our office must have a **signed Authorization to Treat a Minor** form on file **prior to the appointment.**

SHORT CANCELLED / MISSED APPOINTMENT

If you need to cancel or reschedule your appointment, please call our office at least **48** hours before your reserved time. **Cancellations by email or text will not be accepted.** Missed appointments without prior notification will incur a **missed appointment fee,** and future appointments may require a **deposit** to reserve your time.

Thank you for your understanding and cooperation.

INSURANCE AUTHORIZATION – SIGNATURE ON FILE & HIPAA ACKNOWLEDGMENT

I have read and understand all the terms mentioned above and agree with their content. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to accept responsibility for payment of all services rendered on my behalf or the behalf of my dependents.
Further, my signature authorizes Peter Arsenault, D.M.D. to release private health information about me/dependents necessary to provide treatment, process claims for payment, and other healthcare operations. I hereby authorize payment of dental benefits to the provider when an assigned claim is filed.

Signed: _____ Date: _____

Dr. Peter Arsenault, DMD

MISSED APPOINTMENT / DISMISSAL POLICY

At Dr. Peter Arsenault's dental practice, we understand that there may be times when you need to cancel or reschedule your appointment. We ask that you please call us as soon as possible, with **at least 48 hours' notice**. There is often a waiting list for patients to see our providers, and whenever possible, we attempt to fill cancelled spaces with patients who would like to be seen sooner.

To ensure that each patient is given the appropriate amount of time for their visit and to provide the highest quality care, it is very important that patients arrive to their visit on time.

As a courtesy, appointment reminder calls, texts, or emails are sent prior to your scheduled appointment to assist you in keeping your appointment or giving you the opportunity to cancel.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least **48 hours' notice**.
2. If less than a 48-hour cancellation notice is given, the appointment will be documented as a **"Missed Appointment."**
3. If you do not present to the office for your appointment, this will be documented as a **"No-Show" appointment.**
4. After your first "No-Show" or "Missed Appointment," you will receive a phone call and/or letter reminding you that you missed your appointment and offering assistance to reschedule if needed.
5. If you have **two (2) No-Show/Missed Appointments within a two-year time period,** you will receive a written warning letter from our office stating that any additional missed appointments may result in dismissal from the practice. You may also be charged a **$50.00 fee** for the missed appointment.
6. If you have **three (3) No-Show/Missed Appointments within a two-year time period,** dismissal from the practice may be considered. You may also be charged a **$100.00 fee** for the missed appointment. You will be notified by letter if dismissal is approved.
7. Your arrival time is 5 minutes prior to your scheduled appointment. If you arrive more than 10 minutes late, you may be asked to reschedule and may be subject to a missed appointment fee.

Thank you for your understanding and cooperation. This policy allows us to respect the time of all our patients and provide the highest level of care possible.

Signed: _____ **Date:** _____
(PARENT /GUARDAIN)

Printed Patient Name :_____ PHONE: _____