Convivial Dental, P.C
1244 Boylston Street
Chestnut Hill, MA 02467
Tel. (617) 735-0800
Fax. (617) 735-0801

Date___________________________________

PATIENT INFORMATION

Name____ Soc. Sec. # ___________________________
Last Name First Name Initial
Address____
City____ State_______________________ Zip____________________________
Home Phone ( )___________________ Mobile Phone ( ) ____________________ E-Mail Address____________________________
Sex ☐ M ☐ F Age___________________ Date of Birth______________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed by____ Occupation___________________________
Or Full Time Student ☐ College/University____City________________________________
Business Phone_(______)____________________________
Spouse's Name ____ Spouse's Date of Birth____________________________
Spouse Employed by____ Occupation_____________________________________
In case of emergency, who should be notified?____ Phone_(______)___________________
Whom may we thank for referring you? ____

PRIMARY DENTAL INSURANCE

Subscriber's Name____
Last Name First Name Initial
Relation to Patient____ Date of Birth___________________________
Address (if different from patient's)____Phone_(______)______________________
City____State________________________________Zip________________________________
Subscriber Employed by____ Occupation__________________________
Business Phone (______)_________________________
Insurance Company____ Soc. Sec. #___________________________
Contact #___________________________________ Group #________________________________ Subscriber #___________________________

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name____
Last Name First Name Initial
Relation to Patient____ Date of Birth__________________________
Address (if different from patient's)____ Phone (______)_______________________
City____ State________________________________Zip_________________________________
Subscriber Employed by____ Occupation__________________________
Business Phone (______)_________________________
Insurance Company____ Soc. Sec. #___________________________
Contact #___________________________________ Group #________________________________ Subscriber #___________________________

(OVER)

MEDICAL HISTORY

Physician's Name______________________________ Date of Last Physical______________

Have you ever had any serious illnesses or operations?___________ If yes, please describe______________________________

____

Have you ever responded adversely to medical or dental treatment?______________________________

Have you ever had a blood transfusion?___________ If yes, please give the approximate dates______________________________

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Is there anything else we should know about your medical history?______________________________

____

____

MEDICATIONS

Please list any medications you are currently taking:

____

____

Pharmacy Name______________________________

Phone_(______)______________________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other__________________

____

SIGNATURES

CONSENT

I,______________________________ (Name), do hereby request and authorize the dental staff to perform necessary dental services for me, including but not limited to X-rays, and administration of sedatives anesthetics which are deemed advisable by the doctor in my case.

________________ **X** ______________________________

Date Signature

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with______________________________ (Name of Insurance Company(ies))

and assign directly to Convivial Dental, all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that payment for dental services received but not covered, partially or entirely, by insurance is my responsibility.

________________ **X** ______________________________

Date Signature

FINANCIAL AGREEMENT

I agree that I am responsible for all co-payments, patient percentages, deductibles, and balances. I accept full financial responsibility for all charges not covered by insurance.

________________ **X** ______________________________

Date Signature