Comfort
DENTAL WEYMOUTH
SHAHRAM MOGHADDAM, DMD

Dr/Mr/Mrs/Ms/Miss First: _____ Last: _____ Nickname:_____
Name of Guardian (if patient is a minor): _____ Relationship: _____
Date of Birth: _____ SSN: _____ Sex: Male/Female Marital Status: S/M/D/W
Street: _____ City:_____ State:_____ Zip: _____
Employer/School: _____ Occupation: _____
Home Phone: ( ) - Work Phone: ( ) - Cell Phone ( ) - Preferred contact H/W/C
Email Address: _____ May we contact you by email? Yes/No
Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
Name of person financially responsible for this account: _____ Relationship: _____

How did you hear about Comfort Dental Weymouth?
☐Television ☐Brochure ☐Live Nearby ☐Yelp ☐Internet ☐Friend/Relative ☐Other:_____

Insurance Information:

Do you have dental insurance? Yes/ No	Do you have secondary dental insurance? Yes/ No
Subscriber Name	Subscriber Name
Subscriber SSN	Subscriber SSN
Subscriber DOB	Subscriber DOB
Patient Relationship to Subscriber:	Patient Relationship to Subscriber:
Employer Name:	Employer Name:
Employer Phone	Employer Phone
Insurance Company	Insurance Company
Group Number	Group Number
Phone Number	Phone Number

I understand that I am financially responsible for any treatment performed, whether or not I have Dental Insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment that my insurance company does not cover.

*Signature:*_____ *Date:* _____

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED

THE INVESTMENT NECESSARY TO COMPLETE DENTAL TREATMENT IS AN ESTIMATE BASED ON INFORMATION FROM OUR EXAMINATION. SHOULD ADDITIONAL PROBLEMS ARISE AS TREATMENT PROGRESSES, THIS ESTIMATE MAY BE REVISED.

MEDICAL HISTORY INFORMATION

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Do you have any of the following diseases or problems?	Yes	No
Active tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist		

Dental Information

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?			Do you have earaches or neck pain?		
Are your teeth sensitive to cold, hot, sweets, or pressure?			Do you have any jaw discomfort?		
Does food or floss catch between your teeth?			Do you grind your teeth?		
Is your mouth dry?			Do you have any sores or ulcers in your mouth?		
Have you had any periodontal (gum) treatments?			Do you wear dentures or partials?		
Have you ever had orthodontic (braces) treatment?			Do you participate in active recreational activities?		
Is your home water supply fluoridated?			Have you ever had a serious injury to your head or mouth?		
Do you drink bottled or filtered water on a regular basis?			Date of your last dental visit:		
			What was done at that time?		
Are you currently experiencing dental pain or discomfort?			Date of last dental x-rays		

What is the reason for your dental visit today?
How do you feel about your smile?
What is your dental anxiety level? (please circle) (least) 1 2 3 4 5 (most)
Have you had any problems associated with previous dental treatment?

Medical Information

	Yes	No		Yes	No
Are you now under the care of a physician?			Have you had a serious illness, operation, or been hospitalized in the past 5 years?		
Physician's Name: Phone: ( ) -			If yes, what was the illness or problem?		
Address:					
Are you in good health?			Are you taking or have you recently taken any prescription or over the counter medicine(s)?		
Has there been a change in your health within the past year?			If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:		
If yes, what condition is being treated?					

Dental Information

	Yes	No		Yes	No
Do you wear contact lenses?			Joint replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____		
Do you use tobacco?					
Allergies- Are you allergic to or have you had a reaction to: (To all yes responses, specify type of reaction)					
Local anesthetics _____			Metals: _____		
Aspirin: _____			Latex (rubber): _____		
Penicillin or other antibiotics: _____			Iodine: _____		
Barbituarites, sedatives, or sleeping pills: _____			Hay fever/seasonal: _____		
Sulfa drugs: _____			Animals: _____		
Codeine or other narcotics: _____			Food: _____		
			Other: _____ _____		

Please indicate if you have or have had any of the following

	Y	N		Y	N		Y	N
Artificial (prosthetic) heart valve			Autoimmune Disease			Fainting spells/seizures		
Previous infective endocarditis			Rheumatoid Arthritis			Sleep Disorder(Sleep Apnea)		
Damaged valves in transplanted heart			Systemic Lupus Erythematosus			Kidney Problems		
Congenital Heart Disease			Asthma			Special Needs		
Unrepaired, cyanotic CHD			Bronchitis			Osteoporosis		
Repaired (completely) in last 6 months			Emphysema			Persistent swollen glands in neck		
Repaired CHD with residual effects			Hepatitis: Circle A / B / C			Diabetes (Circle Type 1 or Type 2)		
Cardiovascular Disease			AIDS/HIV			Glaucoma		
Angina			Congestive Heart Failure			Stroke		
Arteriosclerosis			Heart Murmur			Damaged Heart Valves		
Heart Attack			Other Congenital Heart Defects			Low Blood Pressure		
High Blood Pressure			Mental Health Disorders			Mitral Valve Prolapse		
Recurrent Infection			Tuberculosis			Neurological Disorders		
Sinus Troubles			Chronic Pain			Cancer/chemotherapy/radiation		
Liver Disease / Jaundice			Malnutrition			Gastrointestinal Disease		
Eating Disorder			Ulcers			Thyroid Problems		
GE Reflux/Heartburn			Sexually Transmitted Disease			Severe headache/migraines		
Severe/rapid weight loss			Excessive Urination			Women: Are you pregnant?		
Has a physician or previous dentist recommended that you take prophylactic antibiotics prior to dental treatment?								

If you answered YES to any of the above questions, or you have a condition that is not listed above, please explain

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his or her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form

Signature of Patient/Guardian: _____ Date: _____

To Our Patients:

Welcome to our office! We are delighted that you have selected us for your dental health care services. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Policy: Payment is due at the time of service. We accept Mastercard, Visa, Discover, American Express, Care Credit, Lending Club, Checks, Debit Card, and Cash.

All overdue accounts will be assessed an annual 18% finance charge and you will be responsible for any collection service fees. There will be a $35.00 fee assessed for any checks returned unpaid.

Insurance Policy: Co-payments are due at the time of service. (ie: Your estimated share of costs that your insurance company will not cover. This amount will be due at the time of service).

We are pleased to assist you in processing your dental insurance. However, dental insurance policies are a contract between the patient and the insurance company. Therefore, we request that you keep your account current with us and personally consult your insurance company for services not covered.

Coupon Offerings: Payments and coupons must be presented at time of check-in.

Cancellation Policy: Please be aware that confirmation calls are a courtesy service only. Patients are responsible for their appointments. If you miss an appointment and fail to notify us at least 24 hours in advance, a missed appointment fee of between $30.00 and $100.00 will be billed to your account.

Thank you again for selecting us as your Dental HealthCare Provider.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Subject to credit approval.However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.