(508) 376-5588 phone
(508) 376-2809 fax
www.MillisDental.com
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MAIN STREET DENTAL
Daniel H. Adler, D.M.D.

P.O. Box 88
1100 Main Street
Millis, MA 02054
adlerdental@comcast.net

1 PATIENT INFORMATION

Date _____

Whom may we thank for referring you? _____

****

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Birth Date _____

SS # _____

Sex: □ Male □ Female Age _____

□ Married □ Widowed □Single

□Minor □Separated □Divorced

****

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

****

Spouse/Parent Name _____

Birth Date _____ SS# _____

2 DENTAL INSURANCE

Primary Dental Insurance Co. _____

Subscriber's Name _____

Subscriber's Employer _____

Group # _____

Birth Date _____ SS# _____

Relationship to Patient _____

****

Secondary Dental Insurance Co. _____

Subscriber's Name _____

Subscriber's Employer _____

Group # _____

Birth Date _____ SS# _____

Relationship to Patient _____

****

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company (ies)
Daniel H. Adler, DMD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental group may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (____)_____

Work (____)_____ Ext _____

Cell (____)_____

Spouse's Work (____)_____

Best time and place to reach you _____

****

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household.)

Name _____

Relationship_____

Home (____)_____

4 FINANCIAL RESPONSIBLITY

Any unpaid balance after 60 days will incur a service charge that will be added to the account. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $500.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection of this account or future outstanding accounts.

_____
Patient Signature

_____
Date

5 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

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

Bad breath	□Yes □No	Fingernail biting	□Yes □No	Orthodontic treatment	□Yes □No
Bleeding gums	□Yes □No	Food collection between teeth	□Yes □No	Pain around ear	□Yes □No
Blisters on lips or mouth	□Yes □No	Grinding teeth	□Yes □No	Periodontal treatment	□Yes □No
Burning sensation on tongue	□Yes □No	Gums swollen or tender	□Yes □No	Sensitivity to cold	□Yes □No
Chew on one side of mouth	□Yes □No	Jaw pain or tiredness	□Yes □No	Sensitivity to heat	□Yes □No
Cigarette, pipe, or cigar smoking	□Yes □No	Loose teeth or broken fillings	□ Yes □No	Sensitivity to sweets	□Yes □No
Clicking or popping jaw	□Yes □No	Mouth breathing	□Yes □No	Sensitivity when biting	□Yes □No
Dry mouth	□Yes □No	Mouth pain with brushing	□Yes □No	Sores or growths in mouth	□Yes □No

How often do you brush _____ How often do you floss _____

6 HEALTH HISTORY

Family Physician's Name _____ Date of last visit _____

Has any doctor told you that you need to take an antibiotic before dental procedures due to a medical condition? Please circle Yes No

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 Valves	□Yes □No	Headaches (Chronic)	□Yes □No	Shortness of Breath	□Yes □No
Artificial Joints	□Yes □No	Heart Murmur	□Yes □No	Sinus Trouble	□Yes □No
Asthma	□Yes □No	Heart Problems	□Yes □No	Stroke	□Yes □No
Back Problems	□Yes □No	Hepatitis Type_____	□Yes □No	Swollen Feet or Ankles	□Yes □No
Bleeding abnormally, with extractions or surgery	□Yes □No	Herpes	□Yes □No	Swollen Neck Glands	□Yes □No
		High Blood Pressure	□Yes □No	Thyroid Problems	□Yes □No
Blood Disease	□Yes □No	Jaundice	□Yes □No	Tonsillitis	□Yes □No
Cancer	□Yes □No	Kidney Disease	□Yes □No	Tuberculosis	□Yes □No
Chemical Dependency	□Yes □No	Liver Disease	□Yes □No	Tumor or growth on head or neck	□Yes □No
Chemotherapy	□Yes □No	Low Blood Pressure	□Yes □No		
Circulatory Problems	□Yes □No	Mitral Valve Prolapse	□Yes □No	Ulcer	□Yes □No
Cortisone Treatments	□Yes □No	Nervous Problems	□Yes □No	Weight Loss, unexplained	□Yes □No
Cough, persistent or bloody	□Yes □No	Pacemaker	□Yes □No		
Diabetes	□Yes □No	Psychiatric Care	□Yes □No		
Emphysema	□Yes □No	Radiation	□Yes □No		

****

Women:

Are you pregnant? □Yes □No Due Date_____ Are you nursing? □Yes □No

Taking birth control pills? □Yes □No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name _____

Phone ( )

ALLERGIES

□Aspirin	□Latex
□Barbiturates (Sleeping pills)	□Local Anesthetic
□Codeine	□Penicillin
□Iodine	□Sulfa

□Other _____