Varinos Dental Associates

Newburyport – Peabody – Burlington – Winthrop–Haverhill

Welcome! Please take a few minutes to complete the information below so that we can get to know you better and provide you with the very best dental care. We look forward to serving your dental needs. Thank you.

First Name: _____ **Last Name**: _____ **MI**:_____

Preferred Name:_____ **Gender**: __Male ___Female

Birth Date:_____ Social Security:_____ **Family Status**:___Married__Single__Child

Email Address:_____

Home Phone:_____ Cell Phone:_____

Address: _____ City:_____State:_____Zip:_____

I am the Patient_____ I am the parent/guardian _____ I am the spouse_____

How would you prefer to be contacted?_____

If you have any family members who are patients in our office, how are you related?_____

How did you hear about our office?_____

Dental Insurance:

Name of Insured:_____

Relationship to Insurance Holder: _____Self _____ Spouse _____Child

Insurance Plan Name: _____

Subscriber Date of Birth:_____

Primary Insurance ID or Social Security #:_____

MEDICAL HISTORY:

PLEASE CHECK ALL THAT APPLY TO YOU. IF YOU INDICATED 'OTHER' PLEASE EXPLAIN AT THE BOTTOM.

Have you had a joint replacement? If yes, when?_____

___AIDS/HIV	___Amoxicillin Allergy	___Allergy-Erythro
___Allergy-N-Saids	___Sulfa Allergy	___Anemia
___Arthritis	___Asthma	___Bisphosphonate Drugs
___Blood Disease	___Blood Thinner Meds	___Cancer
___Codeine Allergy	___CPAP Machine	___Currently Pregnant
___Diabetes	___Dilantin Meds	___Dry Mouth
___Epilepsy	___Glaucoma	___Hay Fever
___Heart Disease	___Heart Murmur	___Hepatitis
___High Blood Pressure	___Hyperthyroidism	___Hypothyroidism
___Immunosuppressed	___Joint Replacement	___Kidney Disease
___Latex Allergy	___Liver Disease	___Low Blood Pressure
___MEDS-BP	___Mental Disorders	___Metal Allergy
___Migraines/Headaches	___Mitral Valve Prolapse	___Nervous Disorders
___NO Epinephrine	___OTHER	___Pacemaker
___Penicillin Allergy	___PREMED	___Radiation Treatment
___Respiratory Problems	___Rheumatic Fever	___Rheumatism
___Seizures	___Sinus Problems	___Smoker
___STD's	___Stomach Problems	___Stroke
___Tuberculosis	___Tumors	___Ulcers

OTHER:_____

Allergy to the following medications:

_____

_____

Currently taking the following medications:

_____

_____

If you have been hospitalized in the last 5 years due to surgery or illness, please explain:

_____

_____

Primary Care Physician's name and telephone number:

_____

_____

Pharmacy Location:

_____

Emergency Contact:

Name:_____ Phone Number:_____

Relationship to individual:_____

If you could change anything about your smile, what would it be? _____

What is the reason for your visit today? _____

When was your last visit to a dentist? _____

Are you interested in Sedation Dentistry? _____

Please take a moment to become familiar with the office policies at Varinos Dental Associates. Please check the line, once you have reviewed this information. Thank you.

Consent for Treatment

____I give permission to Varinos Dental Associates to perform a comprehensive examination necessary to accurately diagnose my treatment needs. I certify that my health history information is accurate to the best of my knowledge and it is my responsibility to inform the office of any changes to my health. I authorize Varinos Dental Associates to perform the necessary dental treatment including the advisable local anesthesia. I understand that no dental procedure will be performed without discussing the necessity with me and obtaining my consent to proceed.

Appointment Policy

____It is our philosophy to put our patients first and to make sure your experience with us is a positive one. We are committed to your oral health, and keeping your scheduled appointments allows us to be partners in your dental care. Your appointment is a reservation. We truly appreciate your courtesy of giving us 48 business hours' notice if you have a conflict with your appointment, and need to reschedule to a different day or time. We will not charge you for your first missed appointment. However, if you miss an appointment a second time within a 12 month span, you may be required to make a deposit when scheduling the next appointment.

Privacy Policy

____We are required by federal and state law to maintain the privacy of your information, and to offer you a copy of our Privacy Practices. You may request a copy of this Notice of Privacy Practices at any time.

Financial Policy:

____It is our goal for our patients to understand their treatment needs, as well as, their financial responsibility before treatment. We welcome cash, check, debit cards, and any of te major credit cards. We are pleased to offer outside financing through CareCredit. All co-payments are due at the time of scheduling your appointment. As a professional courtesy for our patients with dental insurance benefits, we will submit your claim to your dental insurance company. Please understand this is only an estimate and not a guarantee of payment. Any portion not covered by your insurance policy is the responsibility of the patient.

Signature:_____ Date:_____