Welcome to our Practice!

We are delighted to welcome you to our practice and are honored you have chosen us to care for your dental needs. Our mission is to provide our patients with the highest quality dental care available in a comfortable, caring and relaxing environment.

Enclosed you will find several forms and information regarding our office. Please take a moment to complete the registration forms and return them to us as soon as possible by e-mail, fax or mail. We appreciate the opportunity to review your information prior to your first visit.

We look forward to meeting you. If you have any questions or concerns before your first appointment, please feel free to call us. For directions please view the following link:
http://maps.google.com/maps?f=l&hl=en&geocode=&q=Brian+D.+Boynton+D.M.D.,+P.A.+10+Forest+Falls+Drive+Suite+%237&sll=40.575743,-77.265192&sspn=3.625431,7.042236&ie=UTF8&near=Yarmouth,+ME&ll=43.804677,-70.185363&spn=0.013457,0.027509&z=16

Sincerely,

Dr. Brian Boynton and Staff

PATIENT REGISTRATION

Date _____
Name _____ Wishes to be called _____
Male Female Minor Single Married Divorced Widowed Separated
Birth Date _____ Social Security # _____
Address _____
City _____State _____ Zip _____
Telephone: Home _____Work _____
Cell _____ Email _____
Where do you prefer to receive calls? Home Work Cell
When is the best time to reach you? Time _____ Day _____

In the event of an emergency, who should we contact?
Name _____ Relationship _____
Work Tel _____ Home Tel _____
Referred by: Self Family Friend Doctor Other
Name of person making referral _____
Name of person responsible for the account, if different than above _____
Billing Address _____ City _____ State _____Zip _____

MEDICAL HISTORY

Physician's name _____Address _____Tel _____
Last complete medical evaluation _____
Have you been under the care of a medical doctor during the past two years? Yes No
If so, please explain _____
_____
_____
Have you taken any medicine or drugs during the past two years? Yes No
Are you now taking medication? Yes No
If so, please list:

Name of Drug	Dose (strength and # per day)	How long have you taken this medication
1.		
2.		
3.		
4.		
5.		
6.		

Are you allergic to, or have you reacted to, any of the following? Yes No
If yes, please circle:

Aspirin	Penicillin	Tetracycline	Local Anesthetics	Jewelry
Ibuprofen	Erythromycin	Other Antibiotics	Valium	Metals
Percocet	Sulfa drugs	Novocaine	Iodine	
Codeine	Clindamycin	Lidocaine	Latex	

Are you allergic to <u>any other medications</u> or substances? Yes No

If yes, please list:

1.	3.	5.	7.
2.	4.	6.	8.

Do any of the following conditions apply: Yes No

<u>Check all that apply:</u>

□ Heart failure	□ Yellow Jaundice	□ Tuberculosis (TB)	□ Pain in jaw joints
□ Heart disease or attack	□ Liver disease	□ Emphysema	□ Cold sores
□ Angina Pectoris	□ Hepatitis	□ Cough	□ Fever Blisters
□ Heart Murmur	□ Bruise easily	□ Asthma	□ Veneral disease
□ Rheumatic fever	□ Hemophilia	□ Hay Fever	□ Allergies or hives
□ Scarlet Fever	□ Blood transfusion	□AIDS	□ Glaucoma
□ Heart surgery	□ Anemia	□ Stroke	□ Drug Addiction
□ Artificial heart valve	□ Rheumatism	□ Epilepsy or seizures	□ Cosmetic surgery
□ Congenital Heart Lesions	□ Arthritis	□ Nervousness	□ Chemotherapy
□ Low blood pressure	□Artificial joints	□ Diabetes	
□ High blood pressure	□Ulcers	□ Thyroid disease	□ Sinus Trouble
□ Heart pacemaker	□Sickle cell disease	□ Radiation Treatment	
□ Psychiatric Treatment	□Kidney trouble	□ Fainting or Dizzy Spells	

Please explain above checked item_____
_____
_____

Do you need to pre-medicate for Dental Treatment?	Yes	No	Usual pre-med _____
(Women) Might be pregnant?	Yes	No	Due Date _____
Do you have trouble sleeping or any sleep disturbances?	Yes	No	
Do you use tobacco in any form?	Yes	No	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient Name _____

Patient/Guardian Signature _____ Date _____
History Review:

Dentist Signature _____ Date _____

ACKNOWLEDGMENT & RELEASE & INSURANCE

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company. Therefore we do not confirm insurance eligibility or predetermine recommended treatment. We are not preferred providers or members or have any association with any insurance organizations.

Payment

I, _____ agree to be responsible for payment of all services rendered on my behalf or my dependents behalf. I understand payment is due at the time of service unless other arrangements have been made in advance. In the event that payments are not received by agreed upon dates, a 1½ % late charge (18% APR) may be added to my account. If required, a check of my credit history may be made.

Collections

In the event the balance becomes more than 30 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

_____ _____

Signature Date

Primary Insurance Information:

Employee Name: _____
INS CO Name: _____
INS CO Address: _____
INS CO city,st, zip: _____
INS phone: _____
Group/Policy # _____
Employee SS # _____
Birthdate _____

Secondary Insurance Information:

Employee Name: _____
INS CO Name: _____
INS CO Address: _____
INS CO city,st, zip: _____
INS phone: _____
Group/Policy # _____
Employee SS # _____
Birthdate _____