16 Gerrard Avenue
East Longmeadow, MA 01028
413.732.6281

EMADENTAL
PROSTHODONTICS

64 Gothic Street
Northampton, MA 01060
413.584.4900

PATIENT REGISTRATION FORM

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Town: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Date of Birth: _____ SS #: _____ Email: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Referred By: _____ Previous Dentist: _____ Last Seen: _____

Responsible Party (if someone other than patient)

Name: _____

Address _____ **Town**: _____ **State**: _____ **Zip**: __

Home Ph: _____ **Work Ph**: _____ **Cell Ph**: _____

Date of Birth: _____ /_____ /___ **SS #:** _____ **Email**:_____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: _____

Insured Date of Birth: _____ Insurance ID# or Social Security #: _____

Insurance Carrier: _____ Address: _____

Employer's Name: _____ Address: _____

Secondary Insurance Information (if applicable)

Name of Insured: _____ Relationship to Insured: _____

Insured Date of Birth: _____ Insurance ID# or Social Security #: _____

Insurance Carrier: _____ Address: _____

Employer's Name: _____ Address: _____

16 Gerrard Avenue
East Longmeadow, MA 01028
413.732.6281

EMA DENTAL PROSTHODONTICS

64 Gothic Street
Northampton, MA 01060
413.584.4900

Medical History

Patient Name: **Birth Date:** **Date Created:**

Do you see a primary care physician (PCP)? ○ Yes ○ No If yes _____
If yes, please fill in name of PCP

Do you receive care from any medical specialist(s)? If yes, please list ○ Yes ○ No If yes _____

Do you take any medications? If yes, please list ALL below. ○ Yes ○ No

Have you ever taken medication containing biophosphonates? (i.e. Fosamax) ○ Yes ○ No If yes _____

Do you have a joint replacement? ○ Yes ○ No

Do you have a heart valve replacement? ○ Yes ○ No

If YES to either above, what antibiotic do you use to premed for dental appointments? _____

Have you had any major operations/ medical procedures? ○ Yes ○ No If yes _____

Have you had a serious head/neck injury? ○ Yes ○ No If yes _____

Women: Are you...
□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic to any of the following?
□ Aspirin □ Codeine □ Penicillin □ Sulfa Drugs □ Metal □ Latex □ Acrylic
□ Local Anesthetics □ Peanuts/Tree Nuts □ Bee Stings □ Other _____

Do you use controlled substances? ○ Yes ○ No If yes _____

Do you consume alcohol excessively? ○ Yes ○ No

Do you smoke tobacco (or have in the past)? ○ Yes ○ No If yes _____

Do you chew tobacco (or have in the past)? ○ Yes ○ No If yes _____

Do any of the following apply (past or present)?

Acid Reflux (GERD)	O Yes O No	AIDS/HIV Positive	O Yes O No	Allergies (Seasonal)	O Yes O No	Alzheimer's Disease	O Yes O No
Anaphylaxis	O Yes O No	Anemia	O Yes O No	Angina	O Yes O No	Apnea (sleep)	O Yes O No
Apnea CPAP/BIPAP	O Yes O No	Arthritis/Gout	O Yes O No	Artificial Heart Valve	O Yes O No	Artificial Joint	O Yes O No
Asthma	O Yes O No	Blood Clots	O Yes O No	Blood Transfusion	O Yes O No	Cancer in Head/Neck	O Yes O No
Cancer - Other	O Yes O No	Cardiac Arrhythmia (AFIB)	O Yes O No	Cardiac Bypass	O Yes O No	Cardiac Stents	O Yes O No
Cardiovascular Disease	O Yes O No	Celiac Disease	O Yes O No	Chemotherapy	O Yes O No	Chest Pains	O Yes O No
COPD	O Yes O No	Colitis	O Yes O No	Crohn's Disease	O Yes O No	Diabetes Type I	O Yes O No
Diabetes Type II	O Yes O No	Difficulty Breathing	O Yes O No	Dry Mouth	O Yes O No	Eating Disorder	O Yes O No
Emphysema	O Yes O No	Epilepsy/Seizures	O Yes O No	Excessive Thirst	O Yes O No	Fibromyalgia	O Yes O No
Frequent Cough	O Yes O No	Frequent Diarrhea	O Yes O No	Frequent Urination	O Yes O No	Glaucoma	O Yes O No
Heartburn	O Yes O No	Heart Attack/Failure	O Yes O No	Heart Murmur	O Yes O No	Heart Pacemaker	O Yes O No
Hepatitis A	O Yes O No	Hepatitis B / C	O Yes O No	Herpes/ Cold Sores	O Yes O No	High Blood Pressure	O Yes O No
High Cholesterol	O Yes O No	HPV	O Yes O No	Kidney Dialysis	O Yes O No	Kidney Disease	O Yes O No
Leukemia	O Yes O No	Liver Disease	O Yes O No	Low Blood Pressure	O Yes O No	Lyme Disease	O Yes O No
Macular Degeneration	O Yes O No	Migraine Headaches	O Yes O No	Mitral Valve Prolapse	O Yes O No	Multiple Sclerosis	O Yes O No
Parkinson's Disease	O Yes O No	Peripheral Neuropathy	O Yes O No	Psychiatric Care	O Yes O No	Radiation Treatment	O Yes O No
Rheumatic Fever	O Yes O No	Scarlet Fever	O Yes O No	STDs	O Yes O No	Shingles	O Yes O No
Sinus Trouble	O Yes O No	Sjogren's Syndrome	O Yes O No	Sleep Disorder	O Yes O No	Spinal Stenosis	O Yes O No
Stroke	O Yes O No	Swelling of Limbs	O Yes O No	TMJ Disorder	O Yes O No	Thyroid Disease	O Yes O No
Tonsillitis	O Yes O No	Tuberculosis	O Yes O No	Ulcers	O Yes O No	Vertigo	O Yes O No

Have you ever had any serious illness not listed? O Yes O No If yes: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status and/or medication usage.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

16 Gerrard Avenue
East Longmeadow, MA 01028
413.732.6281

EMA DENTAL
PROSTHODONTICS

64 Gothic Street
Northampton, MA 01060
413.584.4900

Dental History

Name: _____ Date: _____

Do you need to pre-medicate for dental appointments Yes No

If yes, what type of antibiotic have you historically used (i.e. amoxicillin, etc.)? _____

Do you …	**Yes**	**No**
1. Have teeth sensitivity to hot, cold or pressure?	_____	_____
2. Have bleeding gums?	_____	_____
3. Experience food catching between your teeth?	_____	_____
4. Have spaces developing between your teeth?	_____	_____
5. Clench or grind your teeth?	_____	_____
6. Experience jaw cracking, popping, or discomfort when you when you open or close your mouth?	_____	_____
7. Have a history of orthodontic treatment (braces)?	_____	_____
8. Have a history of any periodontal (gum) treatment?	_____	_____
9. Have a history of unfavorable dental experiences?	_____	_____
10. Have concerns about the appearance of your teeth?	_____	_____
11. Like the color of your teeth?	_____	_____
12. Have the desire to change the appearance of your teeth if you could?	_____	_____
13. Have old fillings or previous dental treatment that is no longer satisfactory to you?	_____	_____

What type of dental homecare products do you use? _____

Please tell us about any other problems, concerns or questions that you would like to have addressed. We will do our best to listen attentively to your concerns so we can present you with the best possible treatment options.

_____

_____

_____

When was your last…

dental exam_____/_____/_____ last dental cleaning_____/_____/_____

bitewing xrays*_____/_____/____ full mouth series of xrays*_____/_____/_____

panoramic xray*_____/_____/_____

*it will be of utmost importance to know when your last dental xrays were taken, if unsure please call your previous dental health provider to inquire. To avoid need for additional xrays to be taken and associated charges incurred, please make sure to bring recent xrays with you. Bitewings are considered recent if less than 1 year old, full mouth series and panoramic xrays are considered recent if less than 5 years old.

16 Gerrard Avenue
East Longmeadow, MA 01028
413.732.6281

EMADENTAL
PROSTHODONTICS

64 Gothic Street
Northampton, MA 01060
413.584.4900

FINANCIAL ARRANGEMENTS

1. For routine services, payment is due at the time treatment is rendered.
2. For treatment over $500.00, we offer a bookkeeping courtesy of 3 percent of the total fee when payment is made in full with cash or check prior to your appointment.
3. For more complex restorative treatment (crowns, bridgework, dentures, implants, etc...) an initial payment of one-half of the total fee will be required at the beginning of treatment and the balance is due prior to placement of final restoration. Special arrangements may be made upon request.
4. Credit Cards: We accept MasterCard, Visa and Discover, as well as various specialized health/dental financing credit programs including Care Credit, who often offer financing rates as low as 0%.
5. Dental Insurance Plans: Our professional services are rendered to you, the patient, and we feel it is important that financial arrangements be made directly with you. For your convenience our office will submit your insurance claim electronically for reimbursement, and will do our very best to assist you in maximizing the insurance benefits for your treatment.
   - If you would like to know what your insurance benefits will be before you begin treatment, we urge you to contact your carrier directly as *your policy is a contract between you and the insurance carrier*. All charges are your responsibility whether your insurance carrier pays or does not pay.
   - We will be happy to obtain benefit information on your behalf and at your request, however this information will be provided as a courtesy only and should not be construed as guarantee of available benefits or payment by your carrier.

***IMPORTANT NOTE**:* Please keep in mind that if you are able to provide current radiographs from another office, it may keep us from having to retake the radiographs and will, in turn, save you the cost of the service.

PATIENT HIPAA CONSENT FORM

A COMPREHENSIVE DESCRIPTION OF THE NOTICE OF PRIVACY PRACTICES CAN BE FOUND HANGING IN OUR OFFICE OR PROVIDED UPON REQUEST AT ANY TIME

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

a basis for planning my care and treatment
a means of communication among the many health professionals who contribute to my care
a source of information for applying my diagnosis and surgical information to my bill
a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been informed of how to access the complete Notice of Information Practices that provides a more comprehensive description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will inform me of any revised notice and pro- vide me a copy upon my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this con- sent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____
Print Name

_____ _____
Signature of Patient (or Legal Guardian) Date

16 Gerrard Avenue
East Longmeadow, MA 01028
413.732.6281

EMA DENTAL
PROSTHODONTICS

64 Gothic Street
Northampton, MA 01060
413.584.4900

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: _____

Patient Address: _____

Patient Phone Number: _____

I authorize my previous dental care provider (whose information is below) to release my dental x-rays/records or copies of such to EMA Dental:

Name of Previous Doctor or Practice: _____

Address:_____

City:_____ State:_____Zip:_____

_____ _____

Signature of Patient or Legal Guardian Date

Please email records to Info@emadental.com or mail hard copies to:

EMA Dental
16 Gerrard Avenue
East Longmeadow, MA 01028

EMA Dental
64 Gothic Street, Suite 3
Northampton, MA 01060