CDA
COPLEY DENTAL ASSOCIATES

Welcome

"Your oral health is our lifetime commitment"

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date: ____/____/ 20____

PATIENT INFORMATION

Name:_____ Birth date:_____ Sex:_____ Height:_____ Weight: _____

Address: _____ City: _____ State:_____ Zip:_____

E-mail Address: _____

Social Security Number: _____ Home Phone: _____ Mobile Phone: _____

Occupation/Employer: _____ Work Phone: _____

Spouse or Parent's Name: _____ Work Phone: _____

Permanent Address (if different): _____ City: _____ State:_____ Zip:_____

Students (College Name): _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

Do you have or have you had any damaged heart valves or artificial heart valves, including heart murmur? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe: _____	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

☐ Do you have any disease, condition or problem not listed above that you think I should know about? _____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

Local anesthetics ☐ Yes ☐ No

Penicillin or other antibiotics ☐ Yes ☐ No

Sulfa drugs ☐ Yes ☐ No

Aspirin ☐ Yes ☐ No

Codeine or other narcotics ☐ Yes ☐ No

Other _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.

*This form contains **2 pages**, please print on both sides of the same sheet.*

Signature: _____ Date: _____

CDA COPLEY DENTAL ASSOCIATES

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____

Address: _____

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

Check (√) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?: _____ How often do you brush? _____

OFFICE FINANCIAL POLICY

Patients who carry health or dental insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company. Insured patients are expected to take care of their co-payments as services are rendered. If you do not know what your co-payment is, we will expect a minimum of 30% of the fee at the time of service. Uninsured patients are expected to take care of their fees as services are rendered. **We do not bill patients. Payment of the fee is expected at the time of the procedure.** If you have any question about your Insurance we will be happy to assist you. Your eventual reimbursement will be determined by your Insurance Carrier. **Financial Fees, Late Charges, and Collection Charges** may be applied if payments are not received on time. **A $40 charge will be applied per missed appointment if a 24 hours notice is not given to the office.**

Signature: _____ Date: _____

DENTAL INSURANCE

Insurance Company _____ Group # _____ Union or Local # _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relation to Patient: _____

Birth date: _____ Social Security # _____ Date Employed: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

MEDICAL INSURANCE

Insurance Company _____ Group # _____ Union or Local # _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relation to Patient: _____

Birth date: _____ Ins. ID # _____ Date Employed: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Singature of patient or parent if minor Date:

Payment is due in full at time of treatment unless prior arrangements have been approved.

I authorize _____ to keep my signature on file and to charge my credit card account as indicated below:
(name of healthcare provider)

_____ _____

Patients Name Cardholder Name

_____ MO YR _____

Account Number Expiration Date Code Cardholder Signature

CONSENT AND PERMISSION FOR TREATMENT

I hereby authorize Copley Dental Associates and its designee to examine and provide Treatment.

_____ _____

Name Signature

Show the World your most beautiful *Smile*

Venus White
Teeth Whitening Systems

CDA COPLEY DENTAL ASSOCIATES

Copley Dental Associates
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Boston, MA 02116
www.copleydental.com

Patient Smile Assessment

Take a self examination and tell about your smile

Are you pleased with the appearance of your teeth when you smile?
☐ Yes ☐ No

Are you satisfied with the color of your teeth?
☐ Yes ☐ No

Are you pleased with the shape of your teeth?
☐ Yes ☐ No

Are your teeth
☐ Chipped ☐ Protruding ☐ Crooked ☐ Discolored

Do you like the look of your crowns and fillings?
☐ Yes ☐ No

Are your teeth too long? Too short?
☐ Yes ☐ No

Are you missing teeth?
☐ Yes ☐ No

Are you interested in improving the appearance of your teeth?
☐ Yes ☐ No

Are you anxious or fearful of treatment?
☐ Yes ☐ No

Would you like to learn more about modern cosmetic procedures?
☐ Yes ☐ No

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

_____
_____
_____
_____
_____

Ask us about VenusWhite whitening today!