PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

955 Main Street, 101, Winchester, MA 01890 | 781-729-1900 | f:781-729-7102
20 Pond Meadow Drive, 202, Reading, MA 01867 | 781-944-7799 | f:781-944-1804

Pediatric Dentistry
Joseph P. O'Donnell, DMD
Gary Warrington, DMD
Geraldine Garcia-Rogers, DMD
Sonia J. Wu, DMD
Nicole J. Harrington, DMD
Matthew D. Freitas, DMD

Orthodontics
Shannon L. Duffy, DMD
Carolyn J. Ferrick, DMD

Adult Dentistry
Kimberly S. Weiss, DDS

PATIENT INFORMATION (Confidential)

Patient Last Name ________ First Name ________ Home Telephone ________ Birthdate ________

SSN # ________ Gender ________ Street ________ Town ________ Zip ________

Email Address ________ Cell Phone Number ________

Marital Status: ❑ Minor ❑ Single ❑ Separated ❑ Married ❑ Divorced ❑ Widowed

If Student, Name of College ________ City ________ State ________ Full/ Part Time Student ________

If Minor, Parent/ Guardian's Name ________ Birthdate ________ Social Security # ________ Occupation/Employer ________

Guardian's Business Address ________ Work Phone Number ________ Cell Phone Number ________

Spouse/ Parent 2's Name ________ Birthdate ________ Work Phone Number ________ Occupation/Employer ________

Emergency Contact Name ________ Relationship to Patient ________ Phone Number ________

Name of Person Responsible for this Account, IF NOT PATIENT ________ Relationship to Patient ________

Address ________ Home Phone# ________

Email Address ________ Birthdate ________ Cell Phone# ________

Employer ________ Work Number ________ SSN# ________

Whom can we thank for referring you ________

FINANCIAL POLICY Payment Is Due When Services Are Rendered. We accept cash, personal checks, MasterCard, Visa and Care Credit. In the case of divorce or separation, the parent bringing the child to the office will be deemed financially responsible.

APPOINTMENT POLICY If you are unable to keep an appointment, we ask that you give our office at least 24 hours notice. Missed appointment fees may be applicable.

INSURANCE POLICY Your insurance policy is a contract between you, your employer and your insurance company. Therefore, you are responsible for understanding your coverage, benefits and yearly maximum. An authorization will be required to bill your dental insurance company. Please complete the following so that we will have this on file

PRIMARY INSURANCE CARRIER

SUBSCRIBER________
SUBSCRIBER ID#________
SUBSCRIBER'S EMPLOYER________
INSURANCE CARRIER________
GROUP #________
CLAIMS ADDRESS________
CITY________STATE________ZIP________

SECONDARY INSURANCE CARRIER

SUBSCRIBER________
SUBSCRIBER ID#________
SUBCRIBER'S EMPLOYER________
INSURANCE CARRIER________
GROUP #________
CLAIMS ADDRESS________
CITY________STATE________ZIP________

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I am responsible for all copayments, deductibles and rejected charges.

I have read the above information and understand my obligations.

________ ________
Signature of Policyholder Date Signature of Financially Responsible Party Date

MEDICAL HISTORY

Physician________________________________ Office Phone #___________________Last Exam Date_______

1) Are you undergoing medical treatment now? ❑ Yes ❑ No

2) Have you been hospitalized for any surgical operations or serious illness? ❑ Yes ❑No

If yes explain:____

3) Are you taking any medications, including any non prescription medications? ❑ Yes ❑ No

a) If so what medications?____

DRUG	DOSE	FREQUENCY	REASON

4) Have you ever taken Fen-PHen/Redux? ❑ Yes ❑ No

5) Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bispohophonates? ❑ Yes ❑ No

6) Have you ever had a joint replacement? _____ If yes, what_____________and when____________________

7) Do you use Tobacco? ❑ Yes ❑ No

8) Do you use controlled substances? ❑ Yes ❑ No

9) Are you wearing contact lenses? ❑ Yes ❑ No

10) Are you allergic to or have had any reactions to the following?

b) **Local Anesthetics** ❑ Yes ❑ No **Penicillin or other antibiotics** ❑ Yes ❑ No

c) **Barbiturates** ❑ Yes ❑ No **Sedatives** ❑ Yes ❑ No **Iodine** ❑ Yes ❑ No

d) **Aspirin** ❑ Yes ❑ No **Any Metals** (i.e. nickel, mercury, etc.) ❑ Yes ❑No **Latex** ❑ Yes ❑No

e) **Other?** ❑ Yes ❑ No Please list:____

11) Do you have a persistent cough or throat clearing not associated with a known illness lasting > 3 weeks? ❑ Yes ❑No

12) Women only: Are you pregnant or think you may be pregnant? ❑ Yes ❑No

a) Are you nursing? ❑ Yes ❑No b) Are you taking oral contraceptives? ❑ Yes ❑No

9) Have you had or ever been diagnosed with any of the following conditions? Please check **yes or no**.

Y	N		Y	N		Y	N	
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains
❑	❑	Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever/ Allergies
❑	❑	Fainting/ Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy/ Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Diabetes	❑	❑	Joint Replacement/Implant	❑	❑	Heart Trouble
❑	❑	Bone/Joint problems	❑	❑	Hepatitis/ Jaundice	❑	❑	Respiratory Problems
❑	❑	AIDS/ HIV	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse
❑	❑	Thyroid Problem	❑	❑	Stomach Troubles/ Ulcers	❑	❑	Other_________________

DENTAL HISTORY

Name of Previous Dentist/ Location______________________________ Date of Last of Exam__________

Have you had or are experiencing any of at the following:

	Y	N		Y	N
1) Bleeding while brushing or flossing	❑	❑	9) Clench or grind your teeth	❑	❑
2) Teeth sensitivity to hot/ cold liquids or foods	❑	❑	10) Bite your lips or cheeks frequently?	❑	❑
3) Teeth sensitivity to sweet/sour liquids or foods	❑	❑	11) Difficult extractions	❑	❑
4) Painful teeth	❑	❑	12) Prolonged bleeding following extractions?	❑	❑
5) Sores or lumps in or near your mouth?	❑	❑	13) Orthodontic treatment (braces, retainers)	❑	❑
6) Head, neck or jaw injuries?			14) Dentures or partials	❑	❑
7) Clicking in your jaw	❑	❑	If so, date of placement ______________		
Pain (joint, ear, side of face)	❑	❑	15) Specific oral hygiene instruction regarding the care		
Difficulty in opening or closing	❑	❑	of your teeth and gums	❑	❑
Difficulty in chewing	❑	❑	16) Do you like your smile?	❑	❑
8) Frequent headaches?	❑	❑			

Any concerns that you would like to discuss with the dentist?______________________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (or parent/guardian if minor Date

Doctor's Comments____

____

____

____

____

X______________________________________ ____________________

Signature Date