The Flossery

32 South St. #100
Waltham, MA 02453
Phone: 781-894-0500
Fax: 781-209-0234

Date:

PATIENT INFORMATION

Name: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

First Name: ____________________ Last Name: ____________________

Birth Date: ____________________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Not Specify

SSN: ____________________

Driver License: ____________________

Address: ____________________ Apt#: __________

City: __________ State: __________ ZIP*: __________

Home: ____________________

Mobile: ____________________ Carrier: ____________________

Email: ____________________

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Health History

Medical History

1. How did you hear about us? (Google, word of mouth, insurance directory, etc.)

2. What is your most important concern today?

3. On a scale from 1-10 how happy are you with your smile?

4. I would like to learn more about:

Whiter teeth	☐ Yes	☐ No
Straighter teeth	☐ Yes	☐ No
A nicer smile	☐ Yes	☐ No

5. I like to treat problems before they happen. ☐ Yes ☐ No

6. I rather treat issues as they come up. ☐ Yes ☐ No

7. Caries (tooth decay)

Do you consider yourself cavity prone?	☐ Yes	☐ No
Do you consume sugary foods or beverages on a regular basis?	☐ Yes	☐ No
Does your mouth feel dry?	☐ Yes	☐ No
Do you breathe through your mouth?	☐ Yes	☐ No
Do you have heartburn or reflux?	☐ Yes	☐ No

8. Do you have any of the following:

Pregnant	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Hepatitis or liver disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Allergy	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No

Asthma	☐ Yes ☐ No		Tuberculosis	☐ Yes ☐ No
Cancer/Cancer treatment	☐ Yes ☐ No		If yes, what are they	
Fainting spells/seizures	☐ Yes ☐ No			

9. Pharmacology:

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements:

Do you have a desire to reduce the amount of medication you currently take?	☐ Yes ☐ No

10. Periodontal Disease:

Have you been told you have gingivitis or gum disease in the past?	☐ Yes ☐ No
Do your gums ever bleed when you brush or floss?	☐ Yes ☐ No
Do you have gum recession or exposed root surfaces?	☐ Yes ☐ No
Do you have any loose teeth, drifting teeth, or areas that collect food when you eat?	☐ Yes ☐ No
Do you smoke or chew tobacco?	☐ Yes ☐ No

11. Sleep: Do you or your bed partner:

Ever snore?	☐ Yes ☐ No
Experience interruptions in breathing during sleep?	☐ Yes ☐ No
Difficulty sleeping?	☐ Yes ☐ No
Wake up often to use the restroom?	☐ Yes ☐ No
Feel tired or fatigued during the day?	☐ Yes ☐ No
Sleep study history?	☐ Yes ☐ No
Have a CPAP or oral sleep appliance?	☐ Yes ☐ No

12. Function/Bite/TMJ dysfunction:

Do you have any missing teeth other than wisdom teeth?	☐ Yes ☐ No
Do you experience discomfort when chewing?	☐ Yes ☐ No
Do your jaw joints click, pop or make grinding sounds?	☐ Yes ☐ No
Do you experience frequent headaches or jaw/facial pain?	☐ Yes ☐ No
Do your joints ever get stuck or locked?	☐ Yes ☐ No
Do you experience migraines?	☐ Yes ☐ No
Do you have trouble swallowing pills?	☐ Yes ☐ No
Do you feel tired when speaking?	☐ Yes ☐ No
Have you ever been treated for a jaw joint problem?	☐ Yes ☐ No

13. Allergies:

Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal/gum disease? ☐ Yes ☐ No

Are you aware of any allergies? ☐ Yes ☐ No

If so, please list:

14. Anything else you would like us to know prior to your appointment?

15. Physician Information:

Would you like us to send a report of your wellness visit to your primary care doctor? ☐ Yes ☐ No

Please provide your PCPs fax or email:

16. Are you currently under the care of a physician? ☐ Yes ☐ No

If so, for what?

If no, would you like a recommendation for a functional medicine doctor? ☐ Yes ☐ No

Date of last Medical Check up:

Does your physician require you to take special medication before dentistry? ☐ Yes ☐ No

Your Physician's name

Address

Phone

I have read my History and confirm that it adequately reflects past and present conditions.

Authorized signature of covered person (For minor, Parent or Guardian)

Date: ....

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INSURANCE INFORMATION

Primary Insurance

Subscriber Name:

First Name: ______________________

Last name: ______________________

Subscriber D.O.B: ______________________

Subscriber ID: ______________________

Medicaid#: ______________________

Subscriber Address:

____

City: ______________________

State: ______________________

Zip: ______________________

Relation to Subscriber: ◻ Self ◻ Child ◻ Spouse ◻ Other

Employer: ______________________

Insurer: ______________________

Insurer Phone:

Group Plan: ______________________

Group#: ______________________

Secondary Insurance

Subscriber Name:

First Name: ______________________

Last name: ______________________

Subscriber D.O.B: ______________________

Subscriber ID: ______________________

Medicaid#: ______________________

Subscriber Address:

____

City: ______________________

State: ______________________

Zip: ______________________

Relation to Subscriber: ◻ Self ◻ Child ◻ Spouse ◻ Other

Employer: ______________________

Insurer: ______________________

Insurer Phone:

Group Plan: ______________________

Group#: ______________________

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MEDICAL INSURANCE INFORMATION

Primary Insurance

Subscriber Name:

First Name: ____________________

Last name: ____________________

Subscriber D.O.B: ____________________

Subscriber ID: ____________________

Medicaid#: ____________________

Subscriber Address:

____

City: ____________________

State: ____________________

Zip: ____________________

Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer: ____________________

Insurer: ____________________

Insurer Phone:

Group Plan: ____________________

Group#: ____________________

Secondary Insurance

Subscriber Name:

First Name: ____________________

Last name: ____________________

Subscriber D.O.B: ____________________

Subscriber ID: ____________________

Medicaid#: ____________________

Subscriber Address:

____

City: ____________________

State: ____________________

Zip: ____________________

Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer: ____________________

Insurer: ____________________

Insurer Phone:

Group Plan: ____________________

Group#: ____________________

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SIGNATURE ON FILE

I agree that I am responsible for any and all charges billed by The Flossery with respect to such services and care unless the contact between the Flossery and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon unless otherwise provided by law. The undersigned here by authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes my dentist to submit claims for benefits for services rendered or to be rendered without my signature on every claim submitted for my dependants.

Authorized signature of covered person (For minor, Parent or Guardian)

Date:

The undersigned authorizes payment directly to **The Flossery** otherwise payable to him/her

Authorized signature of covered person (For minor, Parent or Guardian)

Date:

A deposit or co-pay is required for all treatments upon booking. All cancellations less than 48 hours ill incur a cancellation fee.

Authorized signature of covered person (For minor, Parent or Guardian)

Date:

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact our office.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider pro viding treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, emails, texts, postcards, or letters).

The undersigned have read and understood the Notice of Privacy.

Authorized signature of covered person (For minor, Parent or Guardian)

Date: ....

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Date:

EMERGENCY CONTACT INFORMATION

Emergency Contact 1

Relation: ☐ Parent ☐ Spouse ☐ Child ☐ Relative ☐ Conservator ☐ Other

First Name: ____________________ Last Name: ____________________

Address: ____ Apt#: __________

City: ____________ State: ____________ ZIP: ____________

Home: ____________ Office: ____________ Mobile: ____________

Pager: ____________ Email: ________________________

Emergency Contact 2

Relation: ☐ Parent ☐ Spouse ☐ Child ☐ Relative ☐ Conservator ☐ Other

First Name: ____________________ Last Name: ____________________

Address: ____ Apt#: __________

City: ____________ State: ____________ ZIP: ____________

Home: ____________ Office: ____________ Mobile: ____________

Pager: ____________ Email: ________________________

Emergency Contact 3

Relation: ☐ Parent ☐ Spouse ☐ Child ☐ Relative ☐ Conservator ☐ Other

First Name: ____________________ Last Name: ____________________

Address: ____ Apt#: __________

City: ____________ State: ____________ ZIP: ____________

Home: ____________ Office: ____________ Mobile: ____________

Pager: ____________ Email: ________________________

Nickname: ....

Favorite color: ....

Favorite book/movie: ....

Favorite song: ....

Favorite superhero/princess: ....

Does your child have any pets? ....

Are you comfortable with your child watching a pre-approved show or video in the office? ....

Any additional information that may help us make your child more comfortable? ....

What is your most important concern today? ....

A balanced smile and bite is important for jaw development, breathing, and aesthetics. Would you be interested in an orthodontic discussion during today's evaluation? ☐ Yes ☐ No

Medical Care:

Does your child:

Have special health care needs? ☐ Yes ☐ No

Have any active medical conditions or disabilities? ☐ Yes ☐ No

Have a history of complications during pregnancy or infancy? ☐ Yes ☐ No

Avoid any recommended preventive services, including vaccinations? ☐ Yes ☐ No

Have health goals you are trying to help him/her achieve? ☐ Yes ☐ No

Who is your child's primary physician?

Does your child have a history of antibiotic therapy for recurring infection(s)? ☐ Yes ☐ No

Are you aware of any allergies? ☐ Yes ☐ No

If so, to what?

Get congested frequently? ☐ Yes ☐ No

Have any history of strep throat, ear infections, or sinusitis? ☐ Yes ☐ No

Does your child have or has been treated for reflux? ☐ Yes ☐ No

Have ADHD-history, behavior disturbances or anxiety attacks? ☐ Yes ☐ No

Exhibit an unhealthy weight (overweight or underweight)? ☐ Yes ☐ No

Get less-than-daily physical exercise? ☐ Yes ☐ No

Get daily exposure to sunlight? ☐ Yes ☐ No

Have more "screen time" than physical play time? ☐ Yes ☐ No

Have ongoing behavior challenges at home or in school? ☐ Yes ☐ No

Does your child have a history of fear, anxiety, or avoidance behavior at a medical/dental appointment? ☐ Yes ☐ No

Has your child seen an orthodontist? ☐ Yes ☐ No

Have constipation? ☐ Yes ☐ No

Diet:

Is your child a slow eater? ☐ Yes ☐ No

If your child a picky eater or avoid certain foods (ex: meat and mashed potatoes)? ☐ Yes ☐ No

Have primary care-givers with a history of adult decay? ☐ Yes ☐ No

Sleep with a bottle? ☐ Yes ☐ No

Consume sugary drinks including juice, soda, and/or sports drinks? ☐ Yes ☐ No

Consume sugary foods such as crackers, breakfast cereals, chewy fruit snacks or candy? ☐ Yes ☐ No

Have a history of tooth decay or an abscessed tooth? ☐ Yes ☐ No

Snack more than twice a day between meals? ☐ Yes ☐ No

Snack or drink anything other than water within an hour of bedtime? ☐ Yes ☐ No

Consumer water from:

- ☐ Tap (city) water
- ☐ Filtered tap water
- ☐ Well (country) water
- ☐ Bottled water

If not tap water, do you know the fluoride content of the water they drink ☐ Yes ☐ No

Use tooth paste with fluoride? ☐ Yes ☐ No

Does your child take any vitamin or probiotic supplements? ☐ Yes ☐ No

If so, what?

Home care:

Receive daily adult-assisted tooth brushing? ☐ Yes ☐ No

Have skills to brush independently? ☐ Yes ☐ No

Receive daily adult-assisted flossing? ☐ Yes ☐ No

Have skills to floss independently? ☐ Yes ☐ No

Have professionally applied sealants? ☐ Yes ☐ No

Sleep/ Airway:

Does your child complain of neck pain or headaches? ☐ Yes ☐ No

Snore or make breathing noises when sleeping? ☐ Yes ☐ No

Breath with his/her mouth open? ☐ Yes ☐ No

Experience bedwetting? ☐ Yes ☐ No

Grind his/her teeth during the day or during sleep? ☐ Yes ☐ No

Does your child sleep, positioning his/her head forward, backwards or with butt in the air? ☐ Yes ☐ No

Does your child sweat in their sleep or need a fan to sleep? ☐ Yes ☐ No

Have oral habits such as finger, thumb or pacifier sucking? ☐ Yes ☐ No

Breathe through his/her mouth rather than nose? ☐ Yes ☐ No

Have a history of receiving breast milk or formula from a bottle rather than breast? ☐ Yes ☐ No

Have a history of difficulty with latching? ☐ Yes ☐ No

Have a tongue-tie or a lip-tie? ☐ Yes ☐ No

Prefer a soft diet over harder-to-chew foods? ☐ Yes ☐ No

Is the child currently in treatment or has had speech therapy? ☐ Yes ☐ No

Do you have any concerns regarding your child’s speech? ☐ Yes ☐ No

Have any issues with speech or articulation of sounds such as "L" or "S"? ☐ Yes ☐ No

Have foods that are difficult to chew? ☐ Yes ☐ No

Choke or gag on foods not chewed well? ☐ Yes ☐ No

Have clicking, popping or pain in either jaw joint? ☐ Yes ☐ No

Injury Prevention and Trauma:

Has your child had a history of falls? ☐ Yes ☐ No

Are there any tooth discolorations that concern you? ☐ Yes ☐ No

Are there any tooth size or tooth position discrepancies that concern you? ☐ Yes ☐ No

Has your child had any surgeries? If so, please list ☐ Yes ☐ No

Is there anything else you would like us to know?

Your Name (Parent/legal guardian): ____________________

Relation to Patient: ____________________

Your signature