JONATHAN M. DAVIS, DMD
FAMILY DENTISTRY

Name _____ Date_____

Telephone (Home)_____Telephone (Work)_____Date of Birth_____

Address_____ S.S.#_____

E-mail address _____(please print clearly)

Person to contact in case of emergency_____Telephone_____

Patient Medical History

Who is your physician?_____Telephone_____

When was your last visit to your physician?_____

	Yes	No
1. Are you under any medical treatment now?.....	____	____
2. Have you ever had a serious illness or major operation?.....	____	____
3. Have you ever had an allergic response to any drugs including penicillin?.....	____	____
4. Has a physician ever informed you that you had: A Heart Ailment or murmur?	____	____
5. High Blood Pressure?.....	____	____
6. Respiratory Disease?.....	____	____
7. Diabetes?.....	____	____
8. Rheumatic Fever?.....	____	____
9. Arthritis or Rheumatism?.....	____	____
10. Tumors or Growths?.....	____	____
11. Any Blood Disease?.....	____	____
12. Any Liver Disease?.....	____	____
13. Any Kidney Disease?.....	____	____
14. Any Stomach Disease?.....	____	____
15. Any Venereal Disease?.....	____	____
16. Hepatitis or Jaundice?.....	____	____
17. Have you tested positive for the HIV virus (AIDS)?.....	____	____
18. Have you ever had a drug or alcohol dependency?.....	____	____
19. Do you have a hip, knee or joint replacement?.....	____	____
20. Are you now taking any drugs or medications?.....	____	____
If yes, what are they? _____		
21. Do you have a history of seizures or epilepsy?.....	____	____
22. Have you ever had any bleeding problems or slowly healing wounds?.....	____	____
23. Have you ever required a blood transfusion?.....	____	____
24. Are you in general good health at this time?.....	____	____
25. Do you smoke?.....	____	____

Patient Dental History

26. Are you currently experiencing any discomfort in your mouth?.....	____	____
27. Have you ever experienced any bleeding from your gums?.....	____	____
28. Are any teeth sensitive to hot, cold, pressure or sweets?.....	____	____
29. Have you ever had any problems with previous dental treatment?.....	____	____
30. Do you ever wake up with jaw pain or headaches?.....	____	____
31. Have you ever had a broken jaw or lost a tooth from an injury?.....	____	____
32. Have you ever had x-ray treatment for a tumor of the head or neck?.....	____	____
33. When was your last full mouth x-ray taken?_____By Whom?_____		
34. At present, do you have any dental complaints?.....	____	____

I HAVE READ AND UNDERSTAND THE HIPAA POLICY FOR THIS OFFICE. I CONSENT TO ROUTINE DENTAL TREATMENT PROVIDED BY THIS OFFICE.

Patient Signature _____Date_____Reviewed_____

JONATHAN M. DAVIS, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Jonathan M. Davis, DMD
Fellow, Academy of General Dentistry
1410 Highland Ave., Suite 203
Needham, MA. 02492
Telephone (781) 444-2669

REQUEST FOR DENTAL RECORDS
(Mail To Previous Dentist)

DATE:_____

Dr. _____

Address: _____

_____

Dear Dr._____,

Our office has received a request for transfer of dental records for the following patient.

Patient Name: _____

Address: _____

_____

We would appreciate if you would forward their records and radiographs to our office. Please notify us if there are any problems with this request.

Signature of patient:_____ Date:_____

Please send to:
Jonathan M. Davis, D.M.D.
1410 Highland Ave.
Needham, Ma. 02492
781-444-2669

Patient Rights

It is your Patient Right:

1) To know what services have been planned for your visit(s).
2) To know the fees for each of these services.
3) To refuse any service you do not want performed at your visit(s).
4) To have your insurance benefits predetermined (at your request)

Your Patient Responsibilities

1) You must give us 24 hour advance notice of appointment changes.
2) Keep us updated of any health or medication changes.
3) You are responsible for payment of annual deductibles, co-payments and costs beyond annual maximum benefits.
4) You are responsible for knowing your own, as well as covered family member's, remaining insurance benefits for the current year
5) You are to notify us promptly of any dental insurance changes.
6) Please remember, submitting your insurance claims is a courtesy provided by our staff.

Patient Name: _____ Date: _____