Polished DNTL LLC Health History

Patient Information (Please print):

Name: _____ _____ M ☐ F ☐ Date of birth: ___/___/___
(first) (last)

Email_____

Day time phone: _____Mailing address:_____

Dental Information:

1. Date of last dental check-up: _____
2. I have an artificial joint, hip or knee replacement or artificial heart valve. YES☐ NO ☐
3. I need to take antibiotics before having dental treatment ☐YES Why?_____☐ NO
4. I have a local dentist YES ☐ NO ☐ Dentist name: _____
5. I need to take antibiotics before having dental treatment ☐YES Why?_____☐ NO

Medical Information:

1. I am under a doctor's care now. YES ☐ for_____ NO ☐
2. I have or had before: Anemia ☐ Asthma ☐ Convulsions ☐ Diabetes ☐ Epilepsy ☐Seizures☐ Glaucoma ☐ Heart Murmur ☐ Heart Problems☐Hepatitis ☐ Kidney/ Liver ☐ Rheumatic Fever ☐ Immune Disorder /HIV/ AIDS ☐ Tuberculosis☐ Other please explain:_____
3. I am taking medicine YES ☐ name of medicine_____NO ☐
4. I am allergic to: Penicillin☐ Antibiotics ☐ Aspirin ☐ Latex ☐ Foods ☐ Other:_____

Other Information:

Race: Black/ African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander ☐ More than one race ☐ I do not wish to answer ☐

Ethnic Origin: Hispanic origin: YES ☐ NO ☐ I do not wish to answer ☐

Privacy: I understand that results of the dental examination and care provided may be shared my dental insurance provider to verify services that were provided, or as required by law or as I permit in writing.

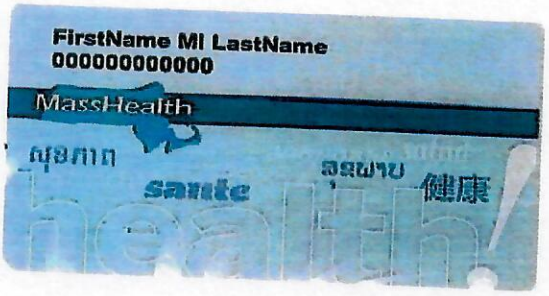
Insurance Information: We are required to notify you that treatment provided may affect your future dental insurance benefits, however, **Polished will make every attempt to NOT impact your twice per year dental cleanings and we never bill for exams. We ask you to contact us if any issues arise involving your benefits**.

I have the following dental insurance:

☐ **MassHealth** RID Number: _ _ _ _ _ _ _ _ _ _ _ _

☐ **Delta** ☐ **BC/BS** ☐ **Other** _____

☐ **No Dental Insurance**



Individual Policy#_____

Group Policy#_____

I agree that the above health information is correct. I give consent for Polished to: provide dental screenings (check teeth, mouth and gums), cleanings (remove plaque and other deposits), fluoride varnish treatments (to protect from cavities) and dental sealants (applied to teeth, when needed, to prevent cavities); to confirm insurance and bill my insurance for care provided. I have read the Polished HIPAA Policy (attached and at www.polishedteeth.com) and understand I may request a copy of the policy for my records. I agree to receive email or phone messages regarding my care. I understand that I may continue to obtain dental care through any other provider.

SIGN HERE _____Date: _____

Contact Information: **Ellen Gould RDH email: ellengould@polishedteeth.com; phone (508) 237-5378**