Big Wide Smiles
FAMILY DENTISTRY
Karen Anne Lunsford D.M.D.

32 Willimansett Street - Rte. 33 - Next to Big Y
South Hadley, MA 01075
P 413.540.9500 / F 413.540.9505
www.bigwidesmiles.com

WELCOME !

Thank you for choosing our office for your dental services. We are located in the Westfield Bank building at the Big Y Plaza - 32 Willimansett Street, South Hadley, MA.

For your convenience, we have attached the initial paperwork for you to complete prior to you visit. Please bring the completed paperwork with you, and any past dental records you may have.

On behalf of our staff, we look forward to meeting you.

Dr. Karen Anne Lunsford

ENCLOSURE : 4 PAGES OF REGISTRATION

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: ____ Preferred Name: _____

Address:_____ City,State,Zip:_____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

We use an automated reminder system to confirm appointments please check all that apply to allow our system to text or email your appointment reminders.

Email: _____ [ ] I can receive correspondence via-email [ ] I can receive via-text messages

Student Status: [ ] Full Time Student [ ] Part Time Student

Preferred Pharmacy:

_____

Responsible Party [ ] Check here if same as above and skip to the next section [ ] Responsible party is also policy holder for patient

Please check if patient is a minor or dependent. [ ] Minor [ ] Dependent

First Name:_____ Last Name:_____ Middle Initial:_____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Primary Insurance Information

Name of Policy Holder: _____ Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Id #: _____ Policy Holder's Birth Date: _____

Insurance Company: _____ Employer: _____

Secondary Insurance Information

Name of Policy Holder: _____ Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Id #: _____ Policy Holder's Birth Date: _____

Insurance Company: _____ Employer: _____

Time 8:16 AM | Big Wide Smiles | Date 1/19/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Big Wide Smiles

Payment in full is expected upon completion of each visit. For your convenience we accept cash, checks, and debit/ATM cards and credit cards. We also participate with the Care Credit as an optional payment plan program. Minimum credit card transaction is $25. There is a return check fee of $30.

As a service to you, our office will submit fees for service to your insurance company. The patient however is the primarily responsible for the account. Any co-payments/deductibles will be collected at the time services are rendered. When payment of insurance claims is assigned to us, that portion of the remaining balances, if any, is the patient's responsibility. If payment from the insurance company is not received within 90 days, it is the responsibility of the patient to pay in full. It also becomes the patient's responsibility to collect from the insurance company because it is the patient who has the contract with the insurance company, not Big Wide Smiles. In addition, this dental office is not responsible for knowing what specific procedures are covered by your insurance policy or the limits of your coverage.

We require a 24 hour notice for cancellation of all scheduled appointments. There will be a $30 charge to your account for all failed appointments and canceled appointments without a prior 24 hour notice. Multiple failed appointments may result in discontinuation of our services.

- I authorize the release of medical information necessary to process claims for dental benefits.
- I authorize payment of benefits to Karen Anne Lunsford d/b/a Big Wide Smiles for services provided.
- I authorize dental treatment as necessary
- I have had the opportunity to review this office's Notice of Privacy Practices as required by HIPAA
- I agree to pay any balance I owe to Big Wide Smiles within 30 days of receiving an invoice for said balance. I agree that if I do not pay my balance within 30 days, finance charges will accrue on the unpaid balance at the rate of one and one half percent per month.
- I understand that legal action may be taken if I fail to fulfill this contract.

_____ _____

Printed name-Parent /Guardian, if patient is a minor or incompetent Date

_____

Signature

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General Consent for Dental Treatment

DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction.) Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs. I have informed the doctor of any known allergies.

Initials_____

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that are not evident during examination. I authorize my dentist to use professional judgement to provide appropriate care.

Initials_____

Fillings

I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that the fillings are rarely "permanent" and will require periodic replacement.

Initials_____

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative bleeding that might require additional treatment, and or post-operative infections
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possible permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Complications during treatment necessitating referral to a specialist

Initials_____

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand treatment plans and fees proposed are subject to modification depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

I understand that any associated laboratory fees are my financial responsibility. I understand I will have the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand that if treatment and anesthesia that are proposed for me, there are known risks and complications.

_____

Patient (Legal Guardian's) Signature Date

_____

Doctor's Signature Date

_____

Dental Office - Witness' Signature Date