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: ____

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:__________

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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

Big Wide Smiles LLC
32 Willimansett Street
South Hadley, MA 01075
413.540.9500

Payment in full is expected upon completion of each visit.
For your convenience we accept cash, checks, debit/ATM cards and credit cards.
The 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 services to your insurance company. Any co - payments will be collected at the time services are rendered. When payment of an insurance claim is assigned to us, that portion of the remaining balance, 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 becomes the patient's responsibility to collect from the insurance company as 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 scheduled appointments.
There will be a $30 charge for all failed appointments or canceled appointments without a 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 Big Wide Smiles LLC 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

____
Signature Date