LUKASIEWICZ & BELLAVANCE LLC

PATIENT INFORMATION

DATE:_____

EMAIL:_____

NAME:_____PREFERRED NAME_____

BIRTHDATE:_____/_____/_____ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE ☐

ADDRESS:_____CITY_____STATE_____

SOCIAL SECURITY #_____/_____/_____ HOME PH#_____CELL#_____

PLACE OF EMPLOYMENT:_____WORK#_____

IF FULL TIME STUDENT, COLLEGE NAME:_____

DENTAL INSURANCE CO:_____SUBSCRIBER#_____GROUP#_____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?_____

WHOM MAY WE THANK FOR REFERRING YOU TO THE OFFICE?_____

FATHER (OR HUSBAND)

_____
LAST FIRST MI

_____
STREET CITY STATE ZIP

_____
BIRTHDATE

_____
EMPLOYER

_____
DENTAL INSURANCE SUBCRIBER # GROUP #

MOTHER (OR WIFE)

_____
LAST FIRST MI

_____
STREET CITY STATE ZIP

_____
BIRTHDATE

_____
EMPLOYER

_____
DENTAL INSURANCE SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____

Address_____

City/State/Zip_____

Telephone #_____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

O Patient O Father (or Husband)

O Guardian O Mother (or Wife)

AUTHORIZATION

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X_____

Patient signature (or if under 18, parent/guardian) Date

LUKASIEWICZ _BELLAVANCE LLC

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

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	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:_____

Lukasiewicz & Bellavance LLC
J. Paul Lukasiewicz, D.M.D., PC
Deborah L. Bellavance, D.M.D., PC
Heather Leung, D.M.D.

Quality, Affordable, Compassionate Dental Care for You and Your Family

In dentistry today, there are several materials available to us to restore your teeth to optimum health. To aid you in deciding which alternative may be best for you, we have developed this list which provides some details about each material and technique.

Silver Amalgam - Amalgam has been used by dentists for over 150 years to restore teeth. It is a mixture of Silver, Nickle, Tin Copper and Zinc using Mercury to mix these components together. Approximately 10 years ago, there was controversy that silver amalgam could expel Mercury in your body at levels high enough to cause systemic diseases such as Multiple Sclerosis or Alzheimer's Disease. This has been proven to be not true by studies done at the National Institute of Health, the F.D.A. and the A.D.A. However, we do know that silver amalgam can and will chip and break teeth as the size of the filling increase. We also know that silver can stain teeth as it ages. The average life span of a silver amalgam is 12-14 years.

Composite - These tooth colored plastic fillings have been used by dentists since the 1970's in different formulations. It is bonded into place and comes in shades to match your tooth color and therefore is more esthetic than silver amalgam, however these plastic fillings are of limited strength. The average longevity is 3 to 6 years before needing replacement. The fee for a composite is approximately 30% more than a comparable sized silver filling. Composite fillings on back teeth are reimbursed at a lower level and can result in greater out of pocket costs for you.

Crowns - A crown or "cap" is a restoration that covers the entire tooth to support it. They are indicated for use in cases where either decay, fracture, of massive fillings have left little of your natural tooth. Crowns are a very predictable restoration that have been used in dentistry for centuries. They are made of gold, porcelain, or a combination of the two. A crown will provide both strength, and a lifelike appearance to your tooth. They have a life span that is significantly longer than amalgam or composite fillings, but requires that we prepare more of your natural tooth to place it. In some cases it may be necessary to perform endodontic therapy or a "root canal" prior to placing a crown. To place a crown typically involves two appointments.

Cerec - A cerec restoration is a computer generated porcelain filling or crown that is bonded into your tooth. When it is bonded in place it will restore the tooth to a strength comparable to the strength of the natural unrestored tooth. It can be placed with a less invasive preparation than a typical crown, preserving more of your natural tooth. The cerec porcelain material comes in colors to closely match your existing tooth shade. It is performed in one visit and has the life span comparable to a traditional crown.

We hope this gives you some insight into the current materials and techniques available to you to restore your teeth. If you have any further questions, please do not hesitate to contact our office.

The above restorative options were presented to me on the date.

Patient Signature **Date**

Baldwin Green Common • Suite #101 • Woburn, MA 01801 • 781-932-5999

Lukasiewicz & Bellavance LLC

Dental History

Please help us to learn more about your dental history by answering the following questions. This series of questions is designed so that we are able to accommodate your specific dental needs.

- What did you like or dislike about your previous Dentist/Dental office?

  _____

- What is the approximate date of your last visit to the Dentist? _____

Dentist Name: _____

Please circle Yes or No to the following:

Do you feel nervous about having dental treatment:? YES / NO

Have you had any trouble associated with previous dental treatment?: YES / NO

Have you ever had gum treatments?: YES / NO

Are you unhappy with your smile?: YES / NO

Do you usually use 'novacaine' for dental treatment?: YES / NO

Missed Appointment Policy

We do our best to keep the cost of your dental treatment as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us with 48 hours notice, another patient who could have been seen was not. This adds to the overall cost of care, as trained personnel and dental facilities are not being utilized.

As a result, we find it necessary to charge **$75.00 fee** for missed appointments without 48 hours notice. In the event you have three (3) missed appointments, we will be unable to afford to help you as a patient, considering the time we lose each time you fail to keep an appointment.

Initials_____

HIPAA

The Health Insurance Portability and Accountability Act

I,_____, have received and reviewed a copy of this office's notice of Privacy Practices.

_____ _____ _____

Printed Name Signature Date