Jason A Boch DMD LLC

Jason A. Boch, DMD DMSc
Diplomate of the American Board of Periodontology

Patient Information

Patient Name:____

Date of Birth:___________ Gender (M/F):________

Name of Parent (if patient is a minor):____

Home Address:____

City:______________________________ State:______________ Zip:_______________

Home phone #:________________________ Work phone #:______________________________

Cell phone #:_________________________ Email:__________________________________

Employer:___________________________ Occupation:________________________________

Social Security #: _____________________________

Dental Insurance Information

Subscriber name:____________________________ Subscriber date of birth:_________________

Dental Insurance Company (Primary):____

Subscriber #: _________________________ Employer: ____________________________

Group#:_______________________________

Dental Insurance Company (Secondary):____

Subscriber name:____________________________ Subscriber date of birth:_________________

Subscriber #: _________________________ Employer: ____________________________

Group#:_______________________________

What dental problem brings you to our office? ____

____

Who recommended you to our office? ____

Who is your restorative/family dentist? ____

Physician's name: ____________________________ Phone number: ________________________

In case of emergency contact name/phone #: ____

____

Patient's Signature (or guardian) Date

Dental History

1. Do you clench or grind your teeth?___________Do you wear an appliance for this?_________
2. Have you had any periodontal treatment or dental implants, please describe?

____

3. Are there any areas in your mouth that have food impaction? ___________________________
4. Are there any areas in your mouth where you do not like how the gingiva looks?___________
5. Have you had orthodontic treatment? ______ When? _________
6. How often do you brush your teeth? ___ each day. Do you use an electric or manual toothbrush _______________ Are the bristles soft/medium/hard? _______________.
7. How often do you floss? ____/week. List anything else you use to clean your teeth ____.

Medical History

1. Please list all medications that you are taking including prescription, non-prescription, and herbal supplements: ____

____

2. Please list any bisphosphonate medications you have taken in the past (such as Fosamax, Zometa, Actonel, Boniva, Aredia) for osteoporosis or cancer: ____________________________

How many years have you taken it?____ Did you ever have it administered intravenously?_____

3. Do you have any allergies including drugs, foods, latex? ________

Please List ____

4. Do you use tobacco products (smoking or smokeless) ______ For how many years? ______

Please List ____

5. Do you require antibiotic premedication before dental appointments (please list the reason for premedication and what you take)? ____

6. If you are female, are you pregnant, or is there a chance you are pregnant? ________________

7. Do you drink alcohol? How much each day? ____

____

Patient's Signature (or guardian) Date

Please mark YES or NO and describe below:

Question	Yes	No
1. Do you have any medical problems/illnesses?	☐	☐
2. Have you had any serious operations?	☐	☐
3. Do you take any blood thinning medications such as aspirin, Coumadin, Plavix, aggrenox? Please list below.	☐	☐
4. Do you have any prosthetic joints, valves, or a heart murmur?	☐	☐
5. Do you have a history of sinus problems or sinus treatment?	☐	☐
6. Any history of cardiac problems, stroke, or high blood pressure	☐	☐
7. Is there any history of treatment for cancer?	☐	☐
8. Have you ever had radiation treatment?	☐	☐
9. Do you bruise or swell easily, or bleed for an excessively long time?	☐	☐
10. Do you have diabetes? How do your blood sugars run?	☐	☐
11. Do you have any organ transplants	☐	☐
12. Have you ever had any of the following: rheumatic fever, asthma, fainting/seizures, liver disease, HIV, gastrointestinal disease, kidney disease, tuberculosis, blood disorder?	☐	☐

Please explain any items from above:

____

____

____

____

Do you have any other medical problems or conditions that the doctor should know about?

____

____

____

Patient's Signature Date

____

Doctor's Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

Jason A. Boch DMD, LLC
109 Andrew Avenue, Ste 201
Wayland, MA 01778

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

Print Name:____

Signature:____

Date:____

* You May Refuse to Sign This Acknowledgment*

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)

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Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.
Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided. I understand that during my course of treatment that the following care may be provided:
Examinations_____ Preventive Services_____
Periodontal treatment_____ Dental implants_____ Other_____

Patient Initials_______

2. Drugs and Medications. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials_______

3. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_______

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Initials_______

_____________________________________ __________________
Patient Signature Date