Lincoln Dental

FRANK A. VOCI, DMD
MARGARET ENNIS DDS
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AVRAHAM SHAINHOUSE DDS

129 LINCOLN STREET

508-754-5891
FAX-508-792-2029

Dear_____,

Welcome to our practice. Our entire team thanks you for selecting our practice for your dental care.

The goal of our office is to provide the highest quality dental experience. We strive to make that experience as gentle, efficient, and pleasant as possible.

Generally, your first visit with our office will include a thorough examination and necessary X-Rays for proper diagnosis, followed by a consultation to discuss your dental needs. The more comprehensive the examination, the more informed we can be in making treatment recommendations. Treatment cost will be discussed and financial arrangements can be made. (New!!!! Ask us about our NO interest payments plans)

In order to save you on time on the day of the appointment, we have enclosed a patient registration form. Please complete the form and bring it with you on the day of your visit. We have also enclosed a card with the date and time we reserved especially for you.

If you have dental insurance, please be sure to bring the most current card, to better assist us in billing the insurance on your behalf. Should you have any further questions, please feel free to contact us at (508) 754-5891.

We look forward to meeting you!

The Lincoln Dental Staff

Directions to our office:
From 290 East: Exit 17, take left onto Belmont, move into right lane, at the commercial street intersection (next to Police Station) veer to the right and continue to the next set of traffic lights. Proceed directly (under the overpass) straight up Lincoln Street. Our office is approximately 2 blocks up on the right at the corner of Lincoln Street and Forestdale Street.

From 290 West: Exit 18, at the intersection take an immediate left up Lincoln St.(under the overpass) Our office is approximately 2 blocks up on the right at the corner of Lincoln and Forestdale Rd.

Welcome to Lincoln Dental

Patient Information **Date:**_____

Name:_____ __Married __Single __Minor __Male __Female
Last First M

Address:_____
Street APT # City State Zip

Home Phone:_____ Work/Cell:_____

Email:_____ If Full-Time Student, School_____

D.O.B:_____ Social Security # _____-_____-_____

Person Responsible For Account: Please Check One:__Patient __Guardian__Spouse__Father__Mother
(Please be aware, in divorce situations, the party bringing in the child for services rendered assumes all responsible for the account)

Insurance Information:

Primary Insured: (If no insurance, please complete for responsible party)

Name:_____ Social Security # _____-_____-_____
Last First MI

D.O.B:_____ Address:_____

Relationship To Patient:_____ Subscriber#:_____

Insurance Company:_____ Employer:_____

Group#_____ Insurance Company Phone #:_____

Secondary Insured:

Name:_____ Social Security # _____-_____-_____
Last First MI

D.O.B:_____ Address:_____

Relationship To Patient:_____ Subscriber#:_____

Insurance Company:_____ Employer:_____

Group#_____ Insurance Company Phone #:_____

Emergency Contact: Name:_____ Phone:_____

Has any member of your family ever been treated in our office? __Yes__No
Whom may we thank for referring you to out office?_____

Authorization: I hereby authorize payment directly to Lincoln Dental insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Lincoln Dental to administer such medications and perform such diagnostic, photographic, 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 this information to third party payors and/or other health professional (See* disclosure below)

X_____ **Date:**_____

Billing Information (Required): In order to keep fees down, we have eliminated paper billing. If we do not receive payment from your Insurance Company, or payment is forwarded directly to patient, or your account becomes delinquent, we reserve the right to charge the Credit Card on file to clear your balance. Please list below the Credit Card you have chosen or we will use any Credit Card (including Care Credit) on file.

____Visa ____MC ____Disc ____Amex ____Care Credit

Account # **Exp Date** _____/_____

X_____ **Date:**_____

***Disclosure: By signing above hereby agree, to accept full responsibility for all charges rendered to this account. Lincoln Dental will make every attempt to collect insurance payments on your behalf but cannot be held responsible if your insurance does not forward payment and/or settles for less than the estimated payment most insurance companies pay. All estimates given are estimates only, and are not a guarantee of payment. Due to the various insurance plans available today, The responsible party assumes full-responsibility for understanding their insurance details and benefits since the contract is between the responsible party and the insurance company.**

PATIENT NAME _____ **DATE**_____

Primary reason for this dental appointment: Examination Emergency Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe_____ Yes No
Do you have dental examinations on a routine basis? Last Visit_____ Yes No
Do you think you have active decay or gum disease?_____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss_____ Yes No
Do you like your smile? Why?_____ Yes No
Does food catch between your teeth? Any loose teeth?_____ Yes No
Do you want to keep your remaining teeth?_____ Yes No
Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind?_____ Yes No
Have your past experiences in a dental office always been positive?_____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss_____ Yes No
Name of previous dentist (optional):_____
Date of last full mouth x-rays (16 small films or panoramic):_____

MEDICAL HISTORY

Are you under a physician's care now? Why?_____ Who?_____ Phone_____ Yes No
Have you ever been hospitalized or had a major operation? Discuss_____ Yes No
Have you ever had a serious injury to your head or neck? Discuss_____ Yes No
Are you taking any medications, pills, or drugs? What?_____ Yes No
Are you on a special diet? Discuss_____ Yes No
Are you allergic to any medications or substances? Please circle below _____ Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other_____

Women (Please check): _Pregnant/trying to get pregnant _Nursing _Taking oral contraceptives
Discuss:_____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Heart Trouble	Yes No	Bruise Easily	Yes No	Emphysema	Yes No	Yellow Jaundice	Yes No
Heart Murmur*	Yes No	Anemia	Yes No	Tuberculosis	Yes No	Kidney Problems	Yes No
Irregular Heart Beat	Yes No	Excessive Bleeding	Yes No	Cancer	Yes No	Renal Dialysis	Yes No
Angina/Chest Pain	Yes No	Sickle Cell Disease	Yes No	X-Ray Treatments	Yes No	Thyroid Disease	Yes No
Heart Attack/Failure	Yes No	Hemophilia	Yes No	Chemotherapy	Yes No	Parathyroid Disease	Yes No
Congenital Heart Disorder	Yes No	Leukemia	Yes No	Stomach Disease	Yes No	Arthritis/Gout	Yes No
Mitral Valve Prolapse*	Yes No	Recent blood Trans.	Yes No	Ulcers	Yes No	Rheumatism	Yes No
Scarlet Fever	Yes No	Swelling of Limbs	Yes No	Recent Weight Loss	Yes No	Pain in Jaw Joints	Yes No
Rheumatic Fever*	Yes No	Lung Disease	Yes No	Frequent Diarrhea	Yes No	Cortisone Medicine	Yes No
Artificial Heart Valve*	Yes No	Breathing Problem	Yes No	Diabetes	Yes No	Artificial Joint	Yes No
Heart Pace Maker*	Yes No	Shortness of Breath	Yes No	Excessive Thirst	Yes No	Venereal Disease	Yes No
Heart Surgery	Yes No	Frequent Cough	Yes No	Hypoglycemia	Yes No	Aids	Yes No
High Blood Pressure	Yes No	Hay Fever	Yes No	Liver Disease	Yes No	HIV Positive	Yes No
Low Blood Pressure	Yes No	Sinus Trouble	Yes No	Hepatitis A (infection)	Yes No	Genital Herpes	Yes No
Blood Disease	Yes No	Asthma	Yes No	Hepatitis B or C	Yes No	Drug Addiction	Yes No
Unexplained Fever	Yes No	Blood Sputum	Yes No	Night Sweats	Yes No	Tattoos	Yes No
Cold Sores	Yes No	Fever Blisters	Yes No	Herpes	Yes No	Stroke	Yes No
Convulsions	Yes No	Epilepsy or Seizures	Yes No	Fainting or Dizziness	Yes No	Glaucoma	Yes No
Tumors or Growths	Yes No	Nervousness	Yes No	Psychiatric Care	Yes No	Alzheimer's Disease	Yes No
Allergies (Medicines)	Yes No	Allergies (Pollen/Dust)	Yes No	Hives or Rash	Yes No	Need Premedication	Yes No

Have you ever had any serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem?_____ Yes No

X_____ Date_____
PATIENT SIGNATURE (PARENT OR GUARDIAN)
Reviewed By Doctor_____ Date_____ BP_____
History Review and Signature Findings_____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
____	_____	None G	_____	____	_____
____	_____	None G	_____	____	_____
____	_____	None G	_____	____	_____

LINCOLN DENTAL

Informed Consent for General 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 recommended procedure, alternative treatments, and 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 you 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 you 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 this form.

1. Treatment to be provided
I understand that during my course of treatment the the following care may be provided:

Examinations_____Preventative Services_____Restorations_____

Crowns_____Bridges_____Other_____ **Patient Initials_____**

2. 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). **Patient Initials_____**

3. Changes in Treatment
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, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
It is Lincoln Dental's policy to provide you with information of procedure and financial changes prior to changing treatment. **Patient Initials_____**

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

_____ _____

Patient Signature **Date**

LINCOLN DENTAL
129 Lincoln St.

Worcester, MA 01605
(508) 754-5891

Frank Voci, D.M..D.
Margaret Ennis D.D.S.

Avraham Shainhouse D.D.S.
Deepti Kalra D.M.D

NOTICE OF PRIVACY PRACTICE

Patient Consent for Treatment, Use and Disclosure of Protected Health Information

I hereby give my consent for Lincoln Dental to treat me, as well as use and disclose protected health information ("PHI") about me to carry out treatment, payment, and healthcare operations ("TPO"). (Lincoln Dental's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent, if I so wish. Lincoln Sq. Dental, reserves the right to revise it's Notice of Privacy Practices at any time. A current or revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at the above address.

With this consent, Lincoln Dental may call my home, or other alternative location, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including, but not limited to laboratory test results.

With this consent, Lincoln Dental may mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including, but not limited to laboratory test results as long as they are marked personal and confidential.

I have the right to request that Lincoln Dental restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. If the practice does not agree, they will inform me in writing of this decision.

BY signing this form, I am consenting to Lincoln Dental to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, I understand that Lincoln Dental may decline to provide treatment to me.

X_____ _____
Signature of patient or legal guardian Date

_____
PLEASE PRINT PATIENT NAME