



CHRISTOPHER J. MAGIERA, DMD. PC

GENERAL DENTISTRY
340 Walnut Street Ext.
Agawam, MA 01001

PATIENT INFORMATION

Date _____ Phone #'s: Home _____ Work _____ Ext _____ Cellular _____

Patient's Name _____ Male Female
First Name Middle Initial Last Name

Birthday ____/____/____ Age _____ Social Security # _____

Single Married Divorced Separated Widow

Residential Address _____
Street City State zip

Employer _____ Occupation _____

In case of emergency, who should be contacted? _____
Name Relationship Phone #

Who is responsible for this account and their relationship to you: _____

Whom may we thank for referring you? _____

If you are a full time student, which school do you go to? _____
School City & State

PRIMARY INSURANCE

SECONDARY INSURANCE

Primary Dental Insurance Company

Secondary Dental Insurance Company

Street City State Zip

Street City State Zip

Phone # _____ Group # _____

Phone# _____ Group # _____

Employer _____

Employer _____

Employee _____

Employee _____

Relationship to patient _____

Relationship to patient _____

Date of Birth ____/____/____

Date of Birth ____/____/____

ID or Social Security Number _____

ID or Social Security Number _____

PAYMENT BY PATIENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. If the patient has dental insurance then the patient's *estimated portion* is due at the time of treatment. A \$25.00 charge will be assessed for any checks returned. Patient's obligation to pay for services shall not be conditioned upon or limited by the types, amounts or availability of insurance. Interest at the rate of 1.5% per month (18% per year), or the maximum amount by law, shall be charged on all sums not paid by Patient as well as a billing fee for each statement mailed. If Patient's account is placed for collection, Patient agrees to pay all costs of collection, including reasonable attorneys' fees.

RESPONSIBLE PERSON (if other than patient):
The undersigned, in consideration for Dentist rendering services to Patient, hereby unconditionally guarantees to Dentist any obligations incurred by Patient. Upon any failure by Patient, at any time, the undersigned shall personally pay all obligations of Patient in accordance with the terms established between Patient and Dentist.

Responsible Party

Date

I, the undersigned patient ("Patient"), hereby authorize my insurance company to pay to Christopher J. Magiera, DMD, PC ("Dentist"), and authorize Dentist to receive direct from the insurance company, all insurance benefits otherwise payable to Patient for services rendered. I also authorize the use of my signature below on all insurance submissions as proof of my authorization. I also authorize Dentist to release all information necessary to secure payments of benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

IF PATIENT IS A MINOR (UNDER AGE 18):
The undersigned parent or guardian, hereby requests and authorizes Dentist to perform necessary dental services for Patient including but not limited to x-rays, fluoride and administration of anesthetics that Dentist deems advisable, regardless of whether or not parent or guardian is actually present at time of treatment. If Patient is a covered person on the undersigned parent or guardian's insurance then, as set forth above, the undersigned authorizes Dentist to take any necessary steps to submit claims and receive payment of benefits from any such insurance policy covering Patient.

Patient Signature

Date

Parent/Guardian Signature

Date





MEDICAL INFORMATION

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 inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

If yes, please explain

Are you under a physician's care now? _____ Yes No _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? _____ Yes No _____

Are you taking any medications, pills, or drugs? _____ Yes No _____

Do you take, or have you taken, Phen-Fen or Redux? _____ Yes No _____

Are you on a special diet? _____ Yes No _____

Do you use tobacco? _____ Yes No _____

Do you use controlled substances? _____ Yes No _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex
 Local Anesthetics Other _____

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

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heart beat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No

Comments _____

Are you happy with the appearance of your teeth? Yes No If no, please explain.

It is the policy of this office to provide all patients, or their parents, guardians or personal representatives a copy of our current Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. Patient's Name _____

I have received a copy of this office's Notice of Privacy Practices:
 (If the patient is a minor or is unable to sign for him or herself, then a parent, guardian or personal representative should sign on patient's behalf):

Date _____ Signature _____ Printed Name _____
 Relationship to patient _____

Office Use Only: We attempted to obtain written acknowledgement & consent but it could not be obtained because:
 Individual refused to sign
 Communications barriers prohibited obtaining the acknowledgement
 Other (please specify) _____

Date _____ Signature _____ Printed Name _____

