PLEASANT STREET
DENTAL ASSOCIATES

DENTAL RECORDS RELEASE FORM

Patient Name to transfer: ____

Date of Birth:______________________Phone number: ______________________

Other family members to transfer: ____

Previous Dentist or Practice Name: ____

Address: ____

City/St/Zip: ____

Phone number:________________________Fax: __________________________

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Pleasant Street Dental Associates.

I hereby give you permission to release any and all of my dental records to Dr. Moshier.

_______________________________   _______________

Patient Signature (parent if a minor)   Date

If records are digital, please email to:
PSD@Pleasantstreetdental.net

Or mail to:
Pleasant Street Dental Associates
53 Pleasant Street
Brunswick, ME 04011

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PATIENT INFORMATION

First Name:________________________________Last Name: _______________________________
Address: ____
____
Phone: H:_____________________W:_____________________C: _____________________
Social Security Number:______-_______- _______
Date of Birth:_______-_______- _______________
E-mail Address ______________________________
Emergency Contact:_________________________Number: _________________________________
Date of Last Dental Visit:______-_______- _______
Date of Last X-rays:______-_______- _______
Referred By: _________________________________

RESPONSIBLE PARTY

First Name:________________________________Last Name: _______________________________
Address: ____
____
Phone: H:_______________________W:_______________________C: _______________________

DENTAL INSURANCE INFORMATION

Name of Insured: ____
Relationship to Patient:____________________________Date of Birth:_______-_______- _______
Home Phone:___________________________Social Security Number:_______-_______- _______
Name of Employer: ____
Insurance Company:____
Address: ____
____
Group Number:_________________________Subscriber ID: _______________________________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ◯ YES ◯ NO
If yes, please complete the following:

Name of Insured: ____
Relationship to Patient:____________________________Date of Birth:_______-_______- _______
Home Phone:___________________________Social Security Number:_______-_______- _______
Name of Employer: ____
Insurance Company:____
Address: ____
____
Group Number:_________________________Subscriber ID: _______________________________

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MEDICAL HISTORY

Patient Name: ______________________________
Date of Birth: ______ - ______ - ______________

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, please explain: ____

Have you ever been hospitalized or had a major operation? YES NO
If yes, please explain: ____

Have you ever had a serious head or neck injury? YES NO
If yes, please explain: ____

Are you taking any medications, pills, or drugs? YES NO
If yes, please explain: ____

Do you take, or have you taken, Fen-Phen or Redux? YES NO
If yes, please explain: ____

Are you on a special diet? ________________

Do you use tobacco products? ________________

Do you use controlled substances? ________________

Are you pregnant or trying to conceive? ________________

Are you taking oral contraceptives? ________________

Are you nursing? ________________

Are you allergic to any of the following?

Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____ Latex _____
Local Anesthetics _____ Other _____

If yes, please explain ____

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Do you have, or have you had, any of the following? (Please Circle YES or NO)

AIDS/HIV Positive	YES	NO	Hemophilia	YES	NO
Alzheimer’s Disease	YES	NO	Hepatitis A	YES	NO
Anaphylaxis	YES	NO	Hepatitis B or C	YES	NO
Anemia	YES	NO	Herpes	YES	NO
Angina	YES	NO	High Blood Pressure	YES	NO
Arthritis/Gout	YES	NO	Hives or Rash	YES	NO
Artificial Heart Valve	YES	NO	Hypoglycemia	YES	NO
Artificial Joint	YES	NO	Irregular Heartbeat	YES	NO
Asthma	YES	NO	Kidney Problems	YES	NO
Blood Disease	YES	NO	Leukemia	YES	NO
Blood Transfusion	YES	NO	Liver Disease	YES	NO
Breathing Problems	YES	NO	Low Blood Pressure	YES	NO
Bruise Easily	YES	NO	Lung Disease	YES	NO
Cancer	YES	NO	Mitral Valve Prolapse	YES	NO
Chemotherapy	YES	NO	Pain In Jaw Joints	YES	NO
Chest Pains	YES	NO	Parathyroid Disease	YES	NO
Cold Sores/Fever Blisters	YES	NO	Psychiatric Care	YES	NO
Congenital Heart Disorder	YES	NO	Radiation Treatments	YES	NO
Convulsions	YES	NO	Recent Weight Loss	YES	NO
Cortisone Medicine	YES	NO	Renal Dialysis	YES	NO
Diabetes	YES	NO	Rheumatic Fever	YES	NO
Drug Addiction	YES	NO	Rheumatism	YES	NO
Easily Winded	YES	NO	Scarlet Fever	YES	NO
Emphysema	YES	NO	Shingles	YES	NO
Epilepsy or Seizures	YES	NO	Sickle Cell Disease	YES	NO
Excessive Bleeding	YES	NO	Sinus Trouble	YES	NO
Excessive Thirst	YES	NO	Spina Bifida	YES	NO
Fainting Spells/Dizziness	YES	NO	Stomach/Intestinal Disease	YES	NO
Frequent Cough	YES	NO	Stroke	YES	NO
Frequent Diarrhea	YES	NO	Swelling of Limbs	YES	NO
Frequent Headaches	YES	NO	Thyroid Disease	YES	NO
Genital Herpes	YES	NO	Tonsillitis	YES	NO
Glaucoma	YES	NO	Tuberculosis	YES	NO
Hay Fever	YES	NO	Tumors or Growths	YES	NO
Heart Attack/Failure	YES	NO	Ulcers	YES	NO
Heart Murmur	YES	NO	Venereal Disease	YES	NO
Heart Pace Maker	YES	NO	Yellow Jaundice	YES	NO
Heart Trouble/Disease	YES	NO			

Have you ever had any serious illness not listed above? YES NO

If yes, please explain: ____

____

____

____

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AUTHORIZATION OF DIRECT PAYMENT

I hereby authorize my insurance company to release direct benefits payable for claims to Pleasant Street Dental Associates. I am also aware that any expenses not covered by insurance are my responsibility.

CANCELLATIONS OR NO SHOWS

We understand that circumstances arise that may prevent you from keeping an appointment. We ask for a 24 hour notice which enables us to better serve the needs of all patients.

First - Cancellation or No Show - Complimentary

Second - Cancellation - $35.00

Second - No Show - $50.00

Third - Cancellation - Grounds for dismissal from the practice

Third - No Show - Grounds for dismissal from the practice

NOTICE OF PRIVACY

I will be given upon request or have been provided with a copy of Pleasant Street Dental Associates Notice of Privacy Practices.

AUTHORIZATION TO: MAIL, CALL, EMAIL or TEXT

There are times when we need to contact you for reasons including but not limited to: Appointment Confirmation, Recommended Treatment or Scheduling Changes/Opportunities. I allow Pleasant Street Dental Associates to contact me per my choice(s) as selected below. Pleasant Street Dental Associates may leave a message with a person at my home or leave a voicemail.

Phone: ________________________________

Email: ________________________________

Text: __________________________________

Patient Name (PRINTED) ______________________________

Patient/Legal Guardian Signature: ______________________________

Date: ______________________________