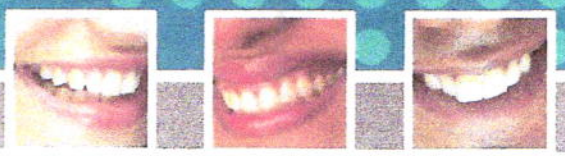
Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



Patient Information Form

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Would you be interested in Sedation Dentistry?

◯ Yes ◯ No

On a scale of 1-10, how nervous are you about coming to the dentist?

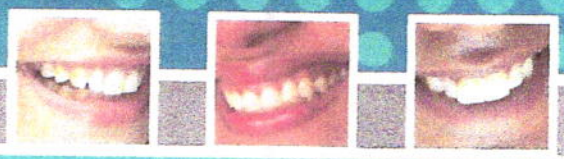
_____

Pharmacy Name and Phone Number

_____

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ City _____ State _____ Zip Code

Primary Insurance

Name of Insured: _____ Last _____ First _____ MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

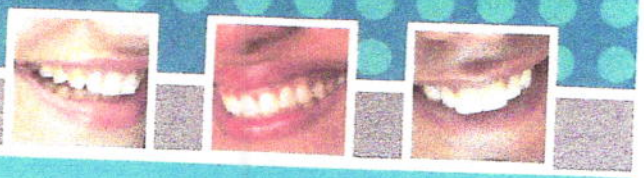
Insurance Address: _____

_____ City _____ State _____ Zip Code

Secondary Insurance

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

Response Date: _____

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your Primary Care Physician's name,address, & phone number

_____

Please mark any of the following to indicate YES in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 2 years due to a surgery or illness?

☐ Are you currently takingany prescriptions or non-prescription medications? Please list below.

☐ Do you use tobacco (smoking or chewing)?

☐ Have you ever had a blood transfusion?

☐ Do you have any other conditions, diseases, etc., not listed that we should be aware of?

If any of the previous questions are marked please explain:

_____

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com

WOMEN ONLY: Are you pregnant or think you may be pregnant?

◯ Yes ◯ No

List of Medications:

Additional Notes:

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] AFIB
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Aspirin
- [ ] Asthma
- [ ] Bisphosphonates
- [ ] Blood Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Cold Sores
- [ ] Depression
- [ ] Diabetes
- [ ] Difficult Swallowing
- [ ] Dizziness
- [ ] Dry Mouth
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lymes Disease
- [ ] Mental Disorders
- [ ] MS
- [ ] Nervous Disorders
- [ ] Osteoporosis
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Premed- Valium
- [ ] Psoriasis
- [ ] PTSD
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tinnitis
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

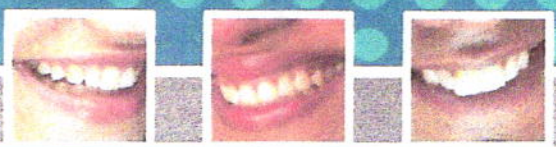
Do you have any other health issues or allergies not listed above?

Do you require antibiotics prior to your dental appointmnt?

◯ Yes ◯ No

If yes, why?

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835
(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



What is the reason for your dental visit today?

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2-6 Weekly ○ 1-6 Monthly ○ Seldom ○ Never

Please mark any of the following to indicate YES in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

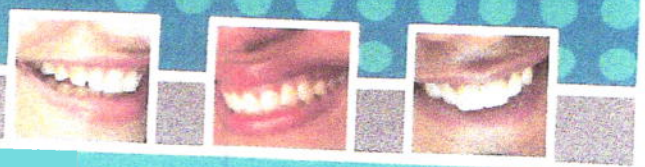
☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



Authorization and Consent for Services

I hereby certfiy that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I hereby authorize and give my consent for Dr. Kuchar/staff to administer such medications and perform such diagnostic and dental treatments as may be necessary for proper dental care. I understand that during treatment it may be necessary to change and add procedures because of conditions found while working on teeth that were not discovered during examination, the most common beinf a root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This offcie will help prepare the patient's insurance forms or assist in making collections from insurnace companies and will credit any cllections to the patient's account. However, this dental office can not render services on the assumption that our charges will be paid by an insurance company.

I authorize Dr. Kuchar to release any information including the diagnosis and records of treatment or examinations for myself and my dependent(s) to third party insurance carriers, payors, and/or healthcare practioners via email, fax telephone, or internet. I authorize my insurance carrier to submit directly to Dr. Kuchar so it may be applied directly to my account.

I understand that I am finnacially responsible for any outstanding balance for services and materials provided that are not covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on my behalf of my dependent(s) if any.

Signature of patient, parent, or guradian:

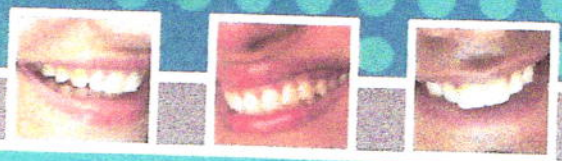
Signature: _____ Date: _____

Relationship to patient: _____

Response Date: _____

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com



Consent For Disclosure of Health Care Information

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

I give Coastal Dental and staff permission to speak with the person (s) listed below regarding my dental health care, including diagnosis, treatment, and payment for services rendered:

Name _____ Phone # _____ Cell # _____

Name _____ Phone # _____ Cell # _____

In addition to sending postcards, I give Coastal Dental and staff permission to provide appointment reminders using: (Check all that apply)

- ☐ Voicemail
- ☐ Answering Machine
- ☐ Texting
- ☐ Email _____
- ☐ Cell Phone # _____

Best Telephone No. to contact me is _____

Emergency Contact: (Name, Phone #, Cell #.) _____

Signature: _____ Date: _____

This Consent is valid until such time as I provide a written revocation of it.

Response Date: _____

Whom may we thank for referring you?

☐ One of our valued patients (name of patient) _____ ☐ Mailing ☐ Google Search

☐ Drive-By ☐ Our Web site ☐ Yelp ☐ Other (Please specify) _____

_____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the first initial visit. We accept the following forms of payment: Visa, Mastercard, Discover, Cash, Check , & Carecredit Financing Credit Card.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We do our best to give you an accurate estimate, however it is not a guarantee of payment. The amount not covered by the dental benefit, is the responsibility of the patient.

Scheduling of Appointments: We reserve the doctor or hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice.

Authorizations: *The information i have given today is correct to the best of my knowledge. I authorize Coastal Dental Associates to perform any necessary dental services that i may need and have consented to during diagnosis and treatment.*

_____**(Initial)**

I have read the above and agree to the financial and scheduling terms. _____**(Initial)**

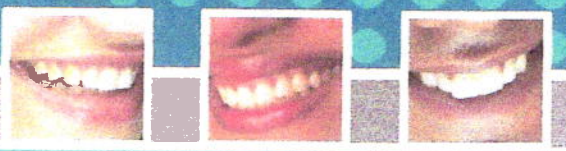
I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____**(Initial)**

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice _____**(Initial)**

Signature_____ **Date** _____

Coastal Dental Associates III, LLC
20 Clinton Ave
Jamestown, RI 02835

(401)423-2110
jamestown@coastaldentalgrp.com
jamestown@coastaldentalgrp.com



Consent for Internet Communications

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

FAIRHAVEN OFFICE
118 Alden Road
Fairhaven, MA 02719
(508) 994-2255

JAMESTOWN OFFICE
20 Clinton Ave
Jamestown, RI 02835
(401) 423-2110

SEEKONK OFFICE
21 Brook St. STE 8
Seekonk, MA 02771
(508) 399-7073

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of:
Notice of Privacy Practices

This document is not a contract, authorization, release, or consent form. This document will remain in your records.

☐ From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check here if you do NOT wish to be notified of such events.

I, _____, acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

_____ _____
Patients Signature Date

_____ _____
Parent or Legal Guardian (if under 18) Date