WELLESLEY DENTAL GROUP
DRS. ALI & ALI

Drs. Ali and Ali
5 Seaward Road
Wellesley, MA
781.237.9071
www.WellesleyDentalGroup.com

Patient Information (CONFIDENTIAL)

Name _____ Title _____ Date of Birth _____ SS # _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Profession _____ Work Phone _____

Spouse or Parent/Guardian's Name _____

Referred by: Patient _____ Organization _____ Website _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

Date of Birth _____ Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ Financial Options

Insurance Information

Name of Insured _____ Relationship _____

Birth date _____ SS # _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Company Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ Relationship _____

Date of Birth _____ SS # _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Are you under medical treatment now? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious injury within the last 5 years?

☐ Yes ☐ No If yes, please explain_____

Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what? _____

Do you use tobacco? ☐ Yes ☐ No If yes, please specify_____

Do you use controlled substances? ☐ Yes ☐ No

Do you require **premedication** before dental appointments? ☐ Yes ☐ No

Are you **allergic** to or have you had any reactions to the following? Check all that apply.

☐ Local Anesthetics (e.g. Novocain) ☐ Sedatives ☐ Latex Rubber

☐ Barbiturates ☐ Penicillin ☐ Other Antibiotics (list below)

☐ Other (please list)_____

Do you have or have you had any of the following? Check all that apply.

☐ High/Low Blood Pressure	☐ AIDS or HIV Infection	☐ Arthritis	☐ Radiation Therapy
☐ Rheumatic Fever	☐ Thyroid Problem	☐ Joint Replacement/Implant	☐ Liver Disease
☐ Fainting/Seizures	☐ Heart Disease	☐ Hepatitis/Jaundice	☐ Mitral Valve Prolapse
☐ Asthma	☐ Cardiac Pacemaker	☐ STD	☐ Tuberculosis
☐ Epilepsy/Convulsions	☐ Anemia	☐ Stomach Troubles/Ulcers	☐ Artificial heart valve
☐ Diabetes	☐ Emphysema	☐ Stroke	☐ Pregnant/Nursing
☐ Kidney Disease	☐ Cancer/Tumor	☐ Hay Fever/Allergies	☐ Other_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor) Date Signature of Dentist Date