

John T. Veale D.M.D., M.P.H.

Peter G. Veale D.M.D.

448 Turnpike St.
S. Easton, MA 02375

45 Slocum Rd.
Dartmouth, MA 02747

Patient Information

Name: (First) _____ (Last) _____ (Middle Initial) _____ (Preferred Name) _____

Address: (Street) _____

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

Date of Birth _____ Male Female

Phone: Home (____) _____ Single Married Divorced Widowed

Work (____) _____ Social Security # _____

Cell (____) _____ Email: _____

Please check primary contact phone number.

How did you hear about us? Yellow Pages Internet Walk in Insurance
 Patient Referral _____ Other _____

Are you currently a full time college student? Y N * If yes, name of college _____

Primary Dental Insurance

Subscriber Name _____ SS # / Subscriber # _____ D.O.B _____

Insurance Co. _____ Insurance Co. Phone # _____

Employer _____ Relation to Patient _____

Secondary Dental Insurance

Subscriber Name _____ Subscriber ID # _____ D.O.B _____

Insurance Co. _____ Insurance Co. Phone # _____

Employer _____ Relation to Patient _____

Dental History (Please indicate if you have had any of the following)

Reason for today's visit _____ Date of last dental visit _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Fingernail biting | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food collection | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Gums swollen / tender | <input type="checkbox"/> Sensitivity cold or hot |
| <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Sensitivity sweets or biting |
| <input type="checkbox"/> Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Sores or growths in mouth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth/fillings | <input type="checkbox"/> How often do you floss _____ |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> How often do you brush _____ |

The information on this page is correct to the best of my knowledge.

Signature _____ **Print** _____ **Date** _____

If Patient is a child: *Parent or Guardian Signature* _____ *Print Name* _____ *Date* _____

John T. Veale D.M.D., M.P.H.

Peter G. Veale D.M.D.

Name _____ Date of Birth _____ SS # _____ Date _____

Primary Care Physician's Name _____ Physician's Phone # _____

Are you currently taking any medications Y N : If yes please list (note: if you have a written list we can take a photo copy)

Has a physician advised you an antibiotic premedication is needed for dental treatment? Y N If yes which RX? _____

Have you had a serious illness or operation? Y N If yes, please describe _____

Are you currently under physicians care? Y N If yes, please describe _____

Best Contact Phone # _____ Occupation: _____

Emergency Contact: Name _____ Relation _____ Phone _____

Medical History and Information (Please indicate if you have had any of the following)

CONDITIONS

- | | | | |
|---|---|--|--|
| Do you smoke / use tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Fainting or Dizzy | <input type="checkbox"/> Pace Maker |
| Are you taking birth control? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Psychiatric Care |
| Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment |
| Are you nursing? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Disease |
| | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever |
| ALLERGIES | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Colitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Swollen Feet/Ankles |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Cough Persistent or Bloody | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Other Allergies _____ | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tonsillitis |
| | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tumor/Growth on Head/Neck |
| | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Other Conditions? _____ |

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Signature _____ PrintName _____ Date _____

JOHN T. VEALE, DMD, MPH

PETER G. VEALE, DMD

**448 TURNPIKE STREET, SUITE 1-5
SOUTH EASTON, MA 02375**

**45 SLOCUM ROAD
DARTMOUTH, MA 02747**

Patient HIPAA Consent Form

In response to the misuse of Personal Health Information (PHI); the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care operation.

We want you to know that we respect the privacy of your medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but not limited to laboratories, pharmacies and other medical offices. As such, we may need to discuss PHI for purposes of treatment, payment and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. This refusal must be in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of you PHI. This refusal must be in writing. However, you may not revoke actions that have already been taken, which relied on this or a previously signed consent.

You may receive a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our office if you have any objections to this consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Date _____

Print Patient Name _____

Signature _____

Relationship to Patient _____