Steven Sepe, DDS
1686 Centre Street
West Roxbury, MA 02132
Phone: 617-323-8970

Medical Alert For Office Use

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

Phone: Home (___) _____ Social Security # _____

Work (___) _____ May we contact you at work? ❑ Yes ❑ No

Mobile(___) _____ ❑ Male ❑ Female

Emergency: Name _____ Phone (___) _____

Email _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize Dr. Steven R. Sepe to obtain a copy of my credit report to consider payment options and allow payment directly to Dr. Steven R. Sepe of the group dental insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment, regardless of whether it is covered by my dental insurance or not. I understand that if my dental insurance does not cover my complete treatment then I am responsible for the balance, and if my insurance covers more than expected I will receive a credit/refund for the difference owed to me.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone (___) _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

When was your last dental appointment? _____

What did you like *most* about your last dentist? _____

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other _____

_____

Y N

❑ ❑ Do you Smoke or use Tobacco?

If Female

Y N

❑ ❑ Are you taking Birth Control Pills?

❑ ❑ Are you pregnant?
If yes, # of weeks_____

❑ ❑ Are you Nursing?

Please list any medications you are currently taking: _____

_____

Treatment Authorization Form

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.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE