TORRISI, BURBA & MARIPURI
DENTAL ASSOCIATES

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient's Name ____ Social Sec. #__________________
Last Name First Name Middle Initial

Address____________________________________ City______________________ State__________ Zip____________

Home Phone # ___________________Cell Phone # ________________________Work Phone #_________________________

Email____

Sex ☐ M ☐ F Age___________ Birthdate____________________ ☐Single ☐Married ☐ Widowed ☐ Divorced

Patient Employed by____ Occupation ____________________________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ________________________________ Phone # __________________________

DENTAL INSURANCE

Person Responsible for Insurance ____
Last Name First Name Middle Initial

Relation to Patient __________________________ Birthdate _________________ Soc. Sec. #____________________________

Address (If different from patient's ____

City____________________________________ State_____________ Zip_____________ Phone #________________________

Person Responsible Employed By____

Insurance Company_______________________________________ Subscriber's ID #__________________________________

Group #____ Insurance Company's Phone # _______________________________

Is patient covered by additional dental insurance? ☐ Yes ☐ No

If yes, please complete the following secondary insurance information.

Insured's Name ____ Relation to Patient ________________________________

Insured's Soc. Sec. # _______________________________________ Insured's Birthdate ________________________________

Insurance Company____ Subscriber's ID #__________________________________

Group #____ Insurance Company's Phone # _______________________________

380 Merrimack St, Ste 3C Methuen, Ma 01844

Tel 978-681-7740 Fax 978-681-5018 office@dentistsmethuen.com

TORRISI, BURBA & MARIPURI
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DENTAL RECORDS RELEASE FORM

I, ____, authorize the release of my dental records to the office of Torrisi, Burba &Maripuri Dental Associates.

____ ____

Date: Patient Signature:

Please forward to: office@dentistsmethuen.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

____ ____

Date: Patient Signature:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

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TORRISI, BURBA & MARIPURI
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OFFICE POLICY AND PROCEDURE

Thank you for choosing Torrisi, Burba & Maripuri Dental Associates. Our primary mission is to deliver the best and most comprehensive dental care available. Our fee is based on the quality materials we use and the time, effort and skill required in performing your treatment. They are reasonable and customary to our area. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options. We accept cash, check, Visa, Mastercard, American Express or Discover Card. For extensive cases/treatment we offer usage of a convenient monthly payment option from Care Credit Healthcare Credit Card. This option allows you to pay overtime with no annual fees or pre-payment penalties. Please ask our front office staff for details.

Payment is due at the time services are rendered. For patients with dental insurances, we are happy to work with your carrier to maximize your benefit and directly bill them electronically for costs of your treatment. Your estimated copayments are due on the date of service.

For all patients with dental insurance, most dental insurances do directly reimburse the dentist, some may only remit payment to the patient. In this case, the patient is responsible for providing payment in full to the office and we will file a claim on your behalf to your carrier for reimbursement.

Should any balance remain unpaid after 60 days or should you violate the terms of your payment agreement, we reserve the right to refer our account to our collection agency. Any fees associated with the collection of these delinquent accounts will be the direct responsibility of the patient.

For the respect of our staff and other patients, we require at least 48 hours notice should you need to cancel/reschedule an appointment. This allows us sufficient time to contact a patient who may be waiting to be moved up into the schedule. Please be advised that at the discretion of the office a fee of $60.00 or more depending on length of appointment, may be applied to your account if not canceled with 48 hours. There will be a $40.00 fee for any returned checks.

We respectfully request that all minors be accompanied by an adult. This allows the staff to make informed decisions regarding the patient's care. If you are unable to accompany your child to his or her appointment, you must provide a phone number where you can be reached should the need arise.

MassHealth patients please be aware multiple no shows or canceled appointments will be reported to M.H.

Please feel free to contact our office with any questions or concerns and our qualified staff will be happy to assist you.

______________________________________ ____________________________

PATIENT SIGNATURE: DATE:

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Burba and Maripuri PLLC

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380 Merrimack Street | Suite 3C • Methuen, MA 01844
(978)681-7740

Patient Name: ______________________ ______________________ ____ ______________

Last First MI Preferred Name

☐ *Pre-Med	☐ A-Fib	☐ ADHD/ADD	☐ Acid Reflux
☐ Addiction	☐ Allergies	☐ Allergy - Latex	☐ Allergy - Medication
☐ Alzheimer's	☐ Amoxicillin	☐ Anemia	☐ Arthritis
☐ Aspirin	☐ Asthma	☐ Augmentin	☐ Autism Spectrum
☐ Autoimmune disease	☐ Bactrim	☐ Bisphosphonates	☐ Blood Clot
☐ Blood Disease	☐ Bone Density issue	☐ COPD	☐ Cancer
☐ Cholesterol	☐ Clindamycin	☐ Crohns Disease	☐ Depression/Anxiety
☐ Diabetes	☐ Difficult Anesthia	☐ Dizziness	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fainting	☐ Flagyl	☐ Glaucoma
☐ HIV/AIDS	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Heart Valve Replaced	☐ Hepatitis	☐ High Blood Pressure	☐ Immunosuppressed
☐ Jaundice	☐ Joint Replacement	☐ Kidney Disease	☐ Latex
☐ Lichen planus	☐ Lisinopril	☐ Liver Disease	☐ MEDS-Blood Thinners
☐ Minocin	☐ Morphine	☐ NSAIDS	☐ Nervousness
☐ Nuts/Tree nuts	☐ OCD	☐ Pacemaker	☐ Penicillin
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ STD
☐ Salicylate sensitive	☐ Seasonal Allergies	☐ Sinus Problems	☐ Sleep Apnea
☐ Stomach Problems	☐ Stroke	☐ Sulfa	☐ Tetracycline
☐ Thyroid Disorder	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Zithromycin	☐ anxiety	☐ bipolar	☐ blood thinners
☐ codeine	☐ erythomycin	☐ ibuprofen	☐ keflex
☐ knee replacement	☐ nut allergy	☐ nuts	☐ osteoporosis
☐ percocet	☐ pregnancy	☐ seafood	☐ seafood
☐ shortness of breathe	☐ spanish speaker	☐ transplant recipient	☐ z OTHER

Please clarify any medical condition(s) listed above or any additional medical conditions: *

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____

Please list any additional allergies including allergies to medications and environmental and food: *

____

____

____

Please list all current medications: *

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____

____

Primary care physician name, telephone, location: *

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____

____

Tobacco use/ history: *

____

____

____

Alcohol consumption: *

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____

____

Recent Hospitalization or Major Illness or Surgery: *

____

____

____

Do you have any artificial joints or hear valve replacements? If yes, please describe: *

____

____

____

Do you require premed antibiotics prior to dental procedures? If yes, please explain? *

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Please Select if any of the following apply?

☐ Snoring ☐ CPAP use ☐ Daytime Sleepiness ☐ Wake up at night gasping for air ☐ NONE OF THE ABOVE

WOMEN ONLY/ Please select if any of the following apply:

☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills ☐ NONE OF THE ABOVE

Additional Notes:

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