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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TORRISI, BURBA & MARIPURI
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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

DENTISTSMETHUEN.COM OFFICE@DENTISTSMETHUEN.COM
380 Merrimack street | Suite 3C • Methuen, MA 01844 (978)681-7740

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

Please select/verify the following medical alerts:

- ☐ *Pre-Med
- ☐ Addiction
- ☐ Anemia
- ☐ Autism Spectrum
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ HIV/AIDS
- ☐ Heart Valve Replaced
- ☐ Immunosuppressed
- ☐ Lichen Planus
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Thyroid Disorder
- ☐ Ulcers
- ☐ A-Fib
- ☐ Allergy - Latex
- ☐ Anxiety
- ☐ Autoimmune Disease
- ☐ Blood Thinners
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Parkinson's disease
- ☐ STD
- ☐ Sleep Apnea
- ☐ Transplant Recipient
- ☐ ADHD/ADD
- ☐ Allergy - Medication
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ Bone Density Issue
- ☐ Crohns Disease
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ OCD
- ☐ Radiation Treatment
- ☐ Seasonal Allergies
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Acid Reflux
- ☐ Alzheimer's
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ COPD
- ☐ Dementia
- ☐ Dry Mouth
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ History of Blood Clots
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Shortness of Breathe
- ☐ Stroke
- ☐ Tumors

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

_____
_____
_____

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

_____
_____

Please list all current medications: *

_____
_____
_____
_____
_____
_____

Primary care physcian name, telephone, location: *

_____
_____

Tobacco use/ history: *

Alcohol consumption: *

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. *

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

Preferred Language:

Additional Notes:

Response Date: _____