James F. Drew, D.M.D.
100 Amesbury Street, Suite 204 Lawrence MA 01840
978-683-5311 Patientcare@jfdrewdmd.com Fax 978-267-6626

PATIENT INFORMATION FORM

Name ______________________ _______________ _______________________________ Date ______________
First Middle Last

Address ____________________________________ City __________________State ___ Zip _________

Home Phone _______________ Cell #_______________ Which phone do you prefer us to call: Home __Cell__

Birthdate ____/____/____ Soc Sec # ____________________ Email ______________________________________

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of spouse, if applicable ____

Is this person currently a patient in our office? Yes No

If college student, FT/PT, name of school ________________________________ City _________________ State ____

Whom may we thank for referring you ____

Emergency Contact Name ______________________________Relationship ____________ Phone ________________

Responsible Party

Person responsible for this account ___________________________________ Relationship to Patient _______________

IF DIFFERENT THAN ABOVE:

Address ____ City _____________________ State ____ Zip _______

Home Phone ________________ Cell #________________ Is this person currently a patient in our office? Yes No

Birthdate ______________ Soc Sec # _________________________

Employer ____

Insurance Information-DENTAL ONLY

Name of Insured____ Relationship to Patient ______________________

(If Insured is different than **Responsible Party**) Birthdate ______________ Soc Sec # ________________________

Name of Employer ________________________________ Work Phone ________________

DENTAL Insurance Co. ________________________ Policy ID# _______________________Group #______________

***Ins Co. Billing Address**: ____Tel # ______________________

Do you have Additional **DENTAL** Insurance? Yes No If **YES**, please complete below

Name of Insured____ Relationship to Patient ______________________

(If different than **ABOVE**) Birthdate ______________ Soc Sec # ________________________

Name of Employer ________________________________ Work Phone ________________

DENTAL Insurance Co. ________________________ Policy ID# _______________________Group #______________

***Ins Co. Billing Address**: ____Tel # ______________________

X ____

Signature of patient (or parent, if minor)

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HEALTH HISTORY

Name ______________________ ________________ ________________________________ Date _______________
First Middle Last

Please list the names and phone numbers of physicians providing your care:
1.____ Phone: ___________________________
2. ____ Phone: ___________________________
3.____ Phone: ___________________________
Have you been hospitalized in the past 5 years? ☐ No ☐ Yes

If yes, reason: ____

Please circle *yes* or *no* for the following conditions:

Anemia or Blood Disorder	No	Yes	Hepatitis, type ______	No	Yes
Arthritis, Rheumatism or any Inflammatory disease	No	Yes	Joint Replacement Date placed _________	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal bleeding from cut	No	Yes	Liver Disease/Jaundice	No	Yes
Cancer or Tumor, Type _______	No	Yes	Sore/enlarged lymph nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/ Lung Illnesses	No	Yes	Radiation or Chemotherapy	No	Yes
Slow-healing mouth sores	No	Yes	Glaucoma	No	Yes
Heart Valve (artificial)	No	Yes	HIV Infection/AIDS or ARC	No	Yes
Heart or Organ Transplant	No	Yes	Venereal Disease	No	Yes
Abnormal heart or previous Bacterial Endocarditis	No	Yes			

Other Conditions/please explain:

____

Are you taking any of these medications?
Have you ever been treated with Bisphosphonate drugs (Fosomax, Aredia, Zometa, Actonel, Boniva) No Yes
If yes, when did the treatment begin? ___________ When did treatment end? ___________

Please list any prescriptions you are currently taking and dosages:

1. ________________________ dosage: ___________
2. ________________________ dosage: ___________
3. ________________________ dosage: ___________
4. ________________________ dosage: ___________
5. ________________________ dosage: ___________
6. ________________________ dosage: ___________

HEALTH HISTORY-Con't

Name ______________________ ___________________ ______________ DOB ________________

First Middle Last

Are you allergic or have you had any reaction to:

LATEX or Metals	No	Yes	**Any Other Allergies (please specify BELOW):**
Penicillin or other antibiotics	No	Yes	
Aspirin, Ibuprofen or Tylenol	No	Yes	
Local anesthetics	No	Yes	
Codeine, Valium or other sedatives	No	Yes	

Women: Are you pregnant? .... No Yes

If no, are you planning a pregnancy in the near future? ..... No Yes

Are you a nursing mother?...........No Yes

Are you taking birth control?.......No Yes

Tobacco, Alcohol, Drugs:

Do you use tobacco? **No Yes** **Type**: smoke chew How much per day?______ For how long? _______

Do you consume alcohol? **No Yes** If **YES**, approximately how many drinks per week? _______________________

Do you use marijuana? **No Yes** If **YES,** how often? _______________

Are you COVID VACCINATED?	YES	NO

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

___________________________________ _____________

Signature of patient (or parent, if minor) Date

I have reviewed the attached Health History. ___________________________ _____________

Signature of Doctor Date

James F. Drew, D.M.D. PC

100 AMESBURY ST STE 204 | LAWRENCE, MA 01840 | (978) 683-5311
email: patientcare@jfdrewdmd.com website: jfdrewdmd.com

Written Financial Policy

Thank you for choosing James F. Drew, DMD. Our primary mission is to deliver the best in comprehensive general dentistry. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Insurance:
We accept most private dental insurance plans including Delta, BC\BS, Guardian, Aetna, Metlife, Altus, and many others.

Payments DUE at FIRST Visit

Appt Type	No Dental Insurance	Has Dental Insurance*
Hygiene appointments	**100%**	**$0**
Dr. appointments	**100%**	**30%**
Pre-treatment estimates **	**50%**	**50%**

*All insurance plans, regardless of coverage levels will have exclusions, deductibles, and limitations for which you will be balance billed from us.
**50% deposit of the expected patient balance is required at your initial treatment appointment;
The remaining 50% is due at the final delivery appointment.

Payments on your Account:
We strive to make dental care affordable. If you CANNOT pay the full amount for any services billed, we do ask that you speak to us so we can set up a payment plan with automatic MONTHLY payments using your credit card.
We are also certified by Care Credit. Care Credit is a healthcare finance solution you may already be using, or may want to explore as an alternative financing option to help you address your dental needs. This program allows you to pay overtime and there are no annual fees or pre-payment penalties. A link is provided from our website.

Cancellation and Failed Appointment Fee:
We respectfully ask that you give us a **24-hour notice** if an appointment needs to be cancelled or re-scheduled. A **FAILED FEE** will be charged for patients who FAIL to show for their scheduled appointment and we reserve the right to increase that fee annually.
It is the responsibility of the patient receiving the voicemail to confirm, cancel or reschedule 24 hours before the scheduled appointment. All reminder calls are documented in the patient's electronic health record (EHR). If the patient's phone is "out of service" or not receiving calls, the patient is still responsible for keeping the scheduled appointment.

Bank Fees:
The bank fee will be passed on and charged to the patient for any returned checks.

I have read and understand the items listed above.

Patient, Parent or Guardian Signature ________________ Patient Name (Please Print) ________________ Date ________

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REQUEST for RECORD RELEASE

Send to Previous Dental Office:

Dr. _____________________________, Date: _____________________

Address: ____

FAX or email: ____

Please accept this as a written request for the release of my Dental records. Please include all current charting, bitewing, periapical and most recent full mouth series of radiographs.

Please transfer to the following dental office:

Dr. James F. Drew, DMD PC
100 Amesbury Street, Suite 204
Lawrence, MA 01840
Office: 978-683-5311 Fax: 978-267-6626
Email: patientcare@jfdrewdmd.com

Thank you,

Patient Signature: ____ Patient DOB: __________________

Printed Patient Name: ____

Address: ____

City, ST, Zip: ____

I hereby request the transfer of records for:

_______ Myself

_______ My Child/Children (for whom I am legal guardian)

Name(s) ____

____

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