Thank you for choosing the Wayland Family Dental Center to serve your dental needs. We are delighted that you will be joining our family of happy and satisfied patients.

Our practice philosophy is centered on the belief that each patient is unique and has individual needs and concerns. We are committed to involving you in your course of treatment and will work closely with you to help you understand all aspects of your oral health and any treatment recommendations that may be made. We are very proud of the care we provide to our patients and strive to impart an exceptional dental experience with each visit.

As a new patient, your initial appointment will include a cleaning (if needed) and a thorough oral evaluation by Dr. Putt. This evaluation will include a comprehensive examination to screen for oral cancer, gum disease, cavities, bite problems, jaw joint problems and broken or damaged teeth. Dr. Putt will evaluate any existing dental work and dental appliances you currently have, and talk with you about your dental concerns. If recent X-rays are not available to bring to this visit, we will recommend X-rays be taken at this appointment. This is critical for a complete and thorough diagnosis of your condition. After the examination, we will discuss any findings and recommended treatment. You can expect to spend between 1 and 1.5 hours for this visit.

Please print the Personal, Health, and Dental Insurance information forms for you to fill out at your convenience. Please bring these forms with you to your appointment.

We look forward to meeting you at your visit. If there is anything that we can do to enhance your experience in our office or if you have any further questions, please feel free to contact us. Thank you, again, for choosing us as your partner in optimizing your oral health.

Sincerely,
Michael A. Putt, D.M.D.

Wayland Family Dental Center

Personal Information

Last Name_____

First Name_____ Middle Initial_____

Date of Birth_____

Home Address_____ MA _____
Street City State Zip Code

Employer _____
Company City State

Home Phone _____ Work Phone _____

Cell Phone_____ Email_____

Whom may we thank for referring you to our office?_____

Dental Information

Date of last dental visit_____

Reason for this visit_____

Have you ever had complications or a poor experience in a dental office? □ Yes □ No
If yes, please explain_____

Do you have any questions or concerns to bring to Dr. Putt's attention? □ Yes □ No
If you do, please explain_____
_____

Would you like a courtesy call to confirm your future appointments? □ Yes □ No
If yes, which number? □ Home □ Work □ Cell □ Email message

Please let us know if there is anything that we can do to make your experience here more comfortable_____
_____

Wayland Family Dental Center

Personal Health Information

Please indicate previous and current medical conditions:

□ Allergy to any medicines _____

□ Allergy to latex or any other material _____

□ Blood diseases _____

□ Heart conditions listed below:

Prosthetic cardiac valves _____

Infective endocarditis _____

Cardiac transplant _____

Congenital heart disease (repairs made with shunts or other prosthetic material) _____

□ Cancer _____

Radiation therapy? □ Yes □ No Chemotherapy? □ Yes □ No

□ Diabetes Last tested blood sugar level_____mg/dl date of last test _____

□ Epilepsy

□ Gastrointestinal conditions _____

□ History of Infectious disease (HIV, Hepatitis, TB etc…) _____

□ Joint replacement therapy_____date_____

Premedication advised prior to dental procedures? □ Yes □ No

□ Kidney or Liver disease _____

□ Musculoskeletal conditions or injuries / Jaw pain _____

□ Osteoporosis

History of medicine to treat? (Actonel, Boniva, Fosamax, Reclast) □ Yes □ No

□ Psychological conditions _____

□ Respiratory conditions / Sleep apnea / Snoring ___ _____

□ Sinus difficulties

□ Stroke date of stroke _____

□ Any other conditions or diseases not listed _____

_____

Physician Information

Primary Care Physician:

Name _____

Number _____

Location _____

Specialist:

Name _____

Number_____

Location _____

Please list all medicines you are currently taking

℞ _____

℞ _____

℞ _____

℞ _____

℞ _____

℞ _____

Patient signature _____ Date _____

Wayland Family Dental Center

Insurance Benefits Information

Primary Insurance

Subscribers Name_____
Last First Middle

Subscribers Date of Birth_____

Subscribers Employer_____ MA _____
Company City State

Insurance Company_____

Insurance Company Address_____
_____

Subscriber ID#_____ Group #_____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other_____

****

Secondary Insurance

Subscribers Name_____
Last First Middle

Subscribers Date of Birth_____

Subscribers Employer_____ MA _____
Company City State

Insurance Company_____

Insurance Company Address_____
_____

Subscriber ID#_____ Group #_____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other_____

We are happy to file your insurance claims on your behalf.
Your estimated balance after insurance benefits will be collected at the time of service.
Our relationship is with you, the patient, and not with your insurance company. Any questions you may have regarding the specifics of your plan should be directed to your insurance company or your employer's HR department.

REQUEST FOR RELEASE OF PATIENT RECORDS

Wayland Dental
Michael A. Putt, D.M.D.
131 Main Street
Wayland, MA 01778
(508) 651-0500
Waylanddental@verizon.net

Date: _____

Request for copy of records and x-rays for our patient:

Name:_____

Address:_____

City, State, Zip:_____

Signature: _____

Previously seen by:

Dentist/Office Name_____

Address:_____

City, State, Zip:_____

Tel:_____ **Fax:**_____

Please E-mail X-rays/Records if possible or mail to:
Thank you

Wayland Dental
Michael A. Putt, D.M.D.
131 Main Street
Wayland, MA 01778
Waylanddental@verizon.net

Phone: (508) 651-0500
Fax: (508) 651-0555