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____
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

RX ____
RX ____
RX ____
RX ____
RX ____
RX ____

Patient signature ___________________________________ Date ______________

Wayland Family Dental Center

Insurance Benefits Information

Primary Insurance

Subscribers Name____
Last First Middle

Subscribers Date of Birth_________________________

Subscribers Employer____
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____
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@gmail.com

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@gmail.com

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