BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.
The primary teaching affiliate of the Boston University School of Medicine.

BOSTON UNIVERSITY

VIKKI NOONAN, DMD, DMSc
Associate Professor
Director of Clinical Oral Pathology, BUSDM
Boston Medical Center

Dear Patient,

Thank you for choosing the Center for Oral Diseases. You are scheduled to see the following doctor:

Vikki Noonan, DMD, DMSc NPI number: 1619980745

In order for your visit to be covered by your medical insurance carrier, it may be required to have a primary care physician referral before you can be evaluated in our specialty practice. Please call your primary care physician's office and ask them to either fax a referral for your visit(s) to the Center for Oral Diseases at 617-638-4697 or send this via e-mail to: ajhamb@bu.edu. Should you have any questions please contact us at 617-638-4775.

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Dear Patient,

This letter confirms your appointment with Dr. Vikki Noonan on _____at _____.

In order to expedite your visit to our office, we have enclosed a patient data form and patient medical history questionnaire. Please fill these forms out completely and bring them to our office on the day of your visit; kindly arrive 20 minutes prior to your appointment to allow for registration. Should it be necessary to cancel or reschedule your appointment, kindly call us with a 24 hour notice.

Please remember to obtain a referral from your primary care physician if that is a requirement of your medical insurance. If your insurance requires a referral and one is not obtained, you will be responsible for any fees. Payment will be required at the time of the appointment. Our office staff is available to process your dental or health insurance forms for reimbursement; we accept MasterCard, Visa, and Discover for your convenience.

Enclosed is a map of the BU Medical Center Campus. Your appointment is at the following location:

Boston Medical Center Moakley Building, 830 Harrison Avenue, Suite 1500, Boston, MA 02118

More information about our center, including directions to our office locations and parking options, can be found at: www.bu.edu/dental/cod. If you have any questions, we can be reached at the Center for Oral Diseases: 617-638-4775.

Sincerely,

Center for Oral Diseases

Boston University Henry M. Goldman School of Dental Medicine
Oral and Maxillofacial Surgery

100 E. Newton Street, G407
Boston, Massachusetts 02118

Patient Data

Name _____ Age _____
Address _____ Date of Birth _____
_____ Sex: M F Married Single Divorced
_____
_____ S.S. #_____
Telephone Numbers: Home _____ Work _____
E-mail _____
Occupation Title or Job Title: _____
Employer:_____
Address:_____
Next of Kin:
Name(s):_____
Relationship to Patient:_____
Address:_____
Home Telephone Number: _____
Employment information: Position, Name of Facility, Town, State, Tel. No. _____
_____
_____
_____

REFERRED BY: _____ **Telephone:**_____
Address: _____

INSURANCE INFORMATION:
1st INSURANCE: NAME OF COMPANY: _____ REFERRAL NUMBER:_____
MEDICAL ADDRESS:_____
PHONE NUMBER:_____
POLICY ID NUMBER: _____
NAME OF SUBSCRIBER AND RELATIONSHIP TO THE PATIENT:_____ SUBSCRIBER'S DOB _____

2nd INSURANCE: NAME OF COMPANY: _____ REFERRAL NUMBER:_____
DENTAL ADDRESS:_____
PHONE NUMBER:_____
POLICY ID NUMBER: _____
NAME OF SUBSCRIBER AND RELATIONSHIP TO THE PATIENT:_____ SUBSCRIBER'S DOB _____

NAME OF PRIMARY CARE PHYSICIAN:_____ REFERRAL NUMBER:_____
ADDRESS: _____
_____
TELEPHONE NUMBER:_____
PROVIDER NUMBER: _____ UPIN NUMBER: _____
MEDICARE PROVIDER NUMBER: _____

I authorize the release of any medical and/or other information necessary to process all my claims. I also authorize any and all third-party benefits to be released directly to BU Oral Surgery Group Practice. I further recognize any outstanding balance after those payments to be my financial responsibility, and I guarantee payment in full.

_____ _____
Signature of guarantor Date

Name: _____ Age _____

BP _____ Pulse _____ Weight _____ Date _____

CIRCLE THE APPROPRIATE RESPONSE:

HAVE YOU EXPERIENCED?

1. Yes No Chest Pain (Angina)
2. Yes No Shortness of breath
3. Yes No Swollen ankles
4. Yes No Recent weight loss, fever, night sweats
5. Yes No Bleeding problems, bruising easily
6. Yes No Difficulty breathing through your nose
7. Yes No Sinus problems
8. Yes No Dizziness or ringing in the ears
9. Yes No Headaches
10. Yes No Fainting spells
11. Yes No Seizures/Epilepsy
12. Yes No Excessive thirst
13. Yes No Dry mouth
14. Yes No Joint pain/Stiffness
15. Yes No Difficulty swallowing
16. Yes No Change in your voice
17. Yes No Jaw joint noises or pain

DO YOU HAVE OR HAVE YOU HAD?

18. Yes No Heart disease
19. Yes No Heart attacks, Heart defects
20. Yes No Heart Murmur
21. Yes No Rheumatic fever
22. Yes No Stroke
23. Yes No High blood pressure
24. Yes No Lung disease
25. Yes No Liver disease, Hepatitis, Jaundice
26. Yes No Stomach problems, ulcer
27. Yes No ALLERGY to medicine, food, other
28. Yes No HIV infection, AIDS, immunodeficiency disease
29. Yes No Cancer/Tumor
30. Yes No Arthritis/rheumatism
31. Yes No Eye disease
32. Yes No Skin disease
33. Yes No Anemia/blood disease
34. Yes No Kidney disease
35. Yes No Thyroid/adrenal disease
36. Yes No Diabetes
37. Yes No Malignant hyperthermia

DO YOU HAVE OR HAVE YOU HAD?

38. Yes No Psychiatric care
39. Yes No Radiation treatment
40. Yes No Chemotherapy
41. Yes No Prosthetic heart valve
42. Yes No Artificial joint
43. Yes No Hospitalization
44. Yes No Blood Transfusion
45. Yes No Surgery
46. Yes No Pacemaker
47. Yes No Contact lenses

DO YOU USE?

48. Yes No Recreational drugs
49. Yes No Alcohol
50. Yes No Over-the-counter medications
51. Yes No Prescription drugs
52. Yes No Tobacco in any form
    Packs per day _____

DO YOU HAVE A FAMILY HISTORY OF?

- ☐ Anesthetic problems
- ☐ Cystic fibrosis
- ☐ Muscular dystrophy
- ☐ Malignant hyperthermia

Are you taking any kind of medicine, drugs, or pills? Please list (especially for bone density, i.e. Bisphosphonates):

_____

_____

PLEASE LIST ANY DRUG ALLERGIES: _____

_____

_____

IS THERE ANYTHING NOT ADDRESSED ABOVE THAT WE NEED TO KNOW ABOUT YOUR HEALTH?

_____

_____

WOMEN ONLY:

53. Yes No Are you or could you be pregnant or nursing
54. Yes No Taking birth control medication

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DOCTOR OF ANY CHANGE IN MY HEALTH AND/OR MEDICATIONS.

SIGNATURE: PATIENT OR LEGAL GUARDIAN: X _____ DATE _____

TREATING DOCTOR'S SIGNATURE: _____ DATE _____

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FINANCIAL AGREEMENT

_____ _____

Patient's Name Appointment Date

I understand that I will be evaluated today by a doctor of the Center for Oral Diseases and there will be professional charges (doctor's fees) for this consultation. It is possible that the consultation visit charges may not be covered by my medical and/or dental insurance plans. If that is the case, I agree to be fully responsible for payment for such services.

I also understand that at the time of the consultation, I will be given a more detailed financial estimate for my specific treatment. I will be responsible for payment of these charges if they are not covered by my medical and/or dental insurance plans.

Patient signature: _____

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Privacy Practices

I, _____, hereby acknowledge that I have reviewed a copy of the Center for Oral Diseases Notice of Privacy Practices. I have been given the opportunity to ask any questions that I may have and to request a copy of the Privacy Practices.

Permission Note

My name is _____. You have my permission to speak with my family regarding my treatment here at the Center for Oral Diseases.

_____ _____
Signature of patient or parent/guardian Date signed

Authorization to Release Photographs

I authorize the Center for Oral Diseases and its doctors to use all photographs taken of _____ (patient name) for use in Educational Journals, Texts, and Presentations.

I may cancel this authorization to the extent allowed by law. If I do decide to cancel this authorization, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of photography by the doctor or practice in reliance on my original authorization. To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to disclose photographs taken of me by this practice.

_____ _____
Signature of patient or parent/guardian Date signed

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BIO SQUARE

Boston HealthNet
Bringing Together the Best