Perry, Weigand and Gurwell Family Dental Care
Registration Information

Name	Date	Name you wish to be called by our staff	
Social Security Number	Date of Birth	Email Address (please print clearly)	
Mailing Address	City	State	Zip code
Employed by	Home Phone	Business Phone	Cell Phone
Your Dental Insurance & Claim Address		Group Number	ID Number
Name of Spouse	Spouse's Date of Birth	Spouse's Social Security Number	
Spouse Employed By	Business Phone	Cell Phone	
Spouse's Dental Insurance & Claim Address (If different from your own.)		Group Number	ID Number
Nearest Relative & Relationship	Address		Phone Number

Please confirm my appointments at: ☐ **Home Phone #** ☐ **Cell Phone #** ☐ **Email Address**

How did you hear about our office? ☐ **Friend/Relative** ☐ **Website** ☐ **Newspaper** ☐ **Yellow Pages** ☐ **I Drove By** ☐ **Other Doctor's Office**______________________

Were you referred by a friend/relative? Please list their name, so we may thank them __________________

Dental History

Are you having any discomfort at this time? ____________________
What is the discomfort? ____________________
How long since you have been to a dentist? ____________________
What was done then? ____________________
Did you have x-rays? ______________
Have you lost any teeth? ___________ Why? ____________________
Have you ever had any complications with extractions? ___________
Have missing teeth ever been replaced by: A bridge _________ RPD _________ Denture _________
Are your teeth sensitive to heat ___________ cold ___________ sweets ___________?
Have you had your teeth straightened? ___________ When? ____________________
How often do you brush your teeth? ___________ When? ____________________
Do you use dental floss? ___________ Any other devices?____________________
Do you have bleeding gums? ___________ When? ____________________
Do you have an unpleasant taste in your mouth? ____________________
Does food wedge between your teeth? ___________ Where? ____________________
Do you grind or clench your teeth? ___________ When? ____________________
Have you ever had gum treatments? ___________ When? ____________________
Have you ever had any pain in or around your ears? ____________________
Do you hear popping, clicking, or snapping noises when chewing? ____________________
Do you have any nasal obstruction? ____________________
Are you aware of any swelling or lump in you mouth? ____________________
Do you have any fear of having dentistry done? ___________ Why? ____________________
How do you feel about your teeth? ____________________

Perry, Weigand and Gurwell Family Dental Care
Medical History

______________________________ ☐ Male ☐ Female ______________________________
Name Date

		Circle	
1.	Are you having dental pain or discomfort at this time?	Yes	No
2.	Do you feel very nervous about having dental treatment?	Yes	No
3.	Have you ever had a bad experience in the dental office?	Yes	No
4.	Have you ever been hospitalized?	Yes	No
5.	Have you been under the care of a medical doctor during the past two years?	Yes	No
6.	Have you taken any medicine or drugs during the past two years?	Yes	No
7.	Do you take aspirin? If so how often? ______________________	Yes	No
8.	Do you have any implants? If so, what type? __________ When placed? __________	Yes	No
9.	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by mint, latex, sulfa drugs, penicillin, aspirin, codeine or any other drugs or medication?	Yes	No
10.	Have you ever had any excessive bleeding requiring special treatment?	Yes	No
11.	Do you use tobacco? In what form? _____________ How much? ________________	Yes	No
12.	Have you had cataract surgery? If yes, date of surgery ________________________	Yes	No

13. Circle any of the following which you have presently or have had previously:

Acid Reflux	Diabetes	Mitral Valve Prolapse
Alcoholism	Drug Addiction	Oral/Genital Herpes
Allergies or Hives	Emphysema	Psychiatric Treatment
Anemia	Epilepsy or Seizures	Radiation Therapy
Angina (chest pain)	Glaucoma	Rheumatic Fever
Anorexia/Bulimia	Heart Disease or Attack	Scarlet Fever
Arthritis	Heart Failure	Sickle Cell Disease
Artificial Heart Valve	Heart Murmur	Sinus Trouble
Artificial Joint	Heart Pacemaker	Sleep Apnea
Asthma	Hemophilia	Stent or Shunt
Bruise Easily	Hepatitis	Stroke
Cancer, Leukemia	High Blood Pressure	Syphilis, Gonorrhea
Chemotherapy	HIV/AIDS	Thyroid Disease
Chronic Cough	Kidney Trouble	Tuberculosis
Cold Sores	Liver Disease	Ulcers
Congenital Heart Lesions	Lyme disease	Venereal Disease

Do you have any disease, condition, or problem not listed? ______________________________________
____
____
____

(OVER)

14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath? Yes No
15. Do your ankles swell during the day? Yes No
16. Have you lost or gained more than 10 pounds in the past year? Yes No
17. Do you use more than 2 pillows to sleep? Yes No
18. Do you ever wake up from sleep short of breath? Yes No
19. Are you on a special diet? Yes No
20. Has your medical doctor ever said you have a cancer or a tumor? Yes No
21. WOMEN: Are you pregnant now? Yes No
    Are you practicing birth control? Yes No
    Do you anticipate becoming pregnant? Yes No
    Are you nursing? Yes No
22. Have you ever been treated for osteoporosis or any other bone disorder? Yes No
23. Are you now or have you ever taken Fosamax, Actonel or Boniva? (circle) Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist or dental staff at the next appointment.

______________________ ______________________________ ______________________________
Date Patient Signature Doctor Signature

____ ______________________________
Emergency Contact Name Emergency Contact Phone Number

Medical History/Physical Update

Physicians Name __________________________________ Phone Number ______________________

Date of last exam _________________________________

Medications Presently Being Taken

Medication	Dosage	Medication	Dosage

Yearly Medical History Update

(Office Use)

Date	Changes	Signature

Perry, Weigand and Gurwell

Family Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME AND DATE OF BIRTH: Include you and/or your **Dependents** (not including Spouse) that you give consent for:

1.____

2. ____

3. ____

4.____

5.____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. The Notice is posted in our reception area. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C:

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.

Signature **(of Responsible Party)** ______________________ Date: ________________________________

If a personal representative **on behalf of the patient** signs this Consent**, complete the following**:

PRINT: Personal Representative's Name: ____

Relationship to Patient: Mother Father Spouse Grandparent Caretaker OTHER _______

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

A. REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ **Date:** ________________________________

FINANCIAL RESPONSIBILITY AND CONSENT TO TREATMENT

To our patients:

Two frequently asked questions are "How much will it cost" and "How can I pay for it?" Before we begin with your treatment, an explanation of the recommended treatment and an estimate of the fees involved will be presented to you either verbally or written for your approval. Your acceptance of treatment and financial responsibility is documented prior to treatment.

The following is our office policy regarding payment for dental services rendered:

- Payment in full is expected at each visit.
- Patients with dental insurance are expected to pay their patient portion at time of treatment.
- Any charges left outstanding after 28 days will be assessed a finance charge of 2% per month. This is an annual percentage rate of 24%.
- If you are unable to pay for treatment in full, we have financing options that are available, upon credit approval. We do not offer monthly billing within the office, but we work with outside financial companies that upon credit approval, can give you monthly billing options. We take the following payment options: Cash, Check, Money Order, MasterCard, Visa, American Express, Discover, and Care Credit.
- In order for us to submit bills to your insurance plan, you must provide us with the name, address, subscriber identification number, group number, subscriber's date of birth, and phone number of the insurance plan prior to your treatment. We will assist you in submitting bills to your insurance plan, but you will remain fully responsible for any and all amounts not paid by your insurance plan within sixty (60) days of service. In the event we subsequently receive payment from your insurance plan, we reserve the right to apply any overpayment to existing unpaid balances.
- If we submit bills to your insurance plan, you agree to pay the full patient portion at the time of service for treatment provided. Even if your insurance pays less than the original estimate given at the time of service, you agree to pay the unpaid portion that was not paid at the time of service.

OVER

- We will provide monthly statements for unpaid balances through ninety (90) days. All accounts unpaid after ninety (90) days will be deemed past due and may be sent to a collection agency. You agree to pay all finance charges and cost of collection, including reasonable attorneys' fees.

- We reserve the right to charge for appointments missed or cancelled without 48 hour notice.

- Unless altered by a divorce decree or child support order, NH law provides that both parents are jointly and severally responsible for treatment provided to their children. We reserve the right to pursue either or both parents in the event of non-payment for services rendered to a child. Notwithstanding the foregoing, the undersigned parent agrees to bear primary responsibility and to serve as the contact person in connection with his/her child's or childrens' account.

- All insurance companies have limitations, and most do not cover 100% of the fee of service. We are considered in-network only with Northeast Delta Dental, but will gladly submit claims for almost all insurance companies. You agree to full responsibility for knowing your insurance benefit program and the limitations of your insurance as it applies to coverage, frequency limits, maximums, deductibles and the usual and customary allowance of fees.

- I hereby authorize any insurance benefits to be paid directly to Perry, Weigand and Gurwell Family Dental Care (the "Practice") and recognize my responsibility to pay for all non-covered services.

- In the event that your insurance plan sends reimbursement directly to you, the Practice is not responsible for the submission of your dental claims and you must submit your claims yourself.

- I also authorize the Practice to release any information necessary to process an insurance claim or to otherwise obtain payment for services rendered.

I hereby give my consent to be treated on an ongoing basis by the dentists and other clinical personnel of Perry, Weigand and Gurwell Family Dental Care. I understand that I have the right to revoke this consent in writing, at any time, except to the extent that a dentist or other clinical provider has taken action in reliance on my consent previously given. I have read and understand and I agree to the financial terms and conditions set forth above.

Please Print:
Name of Patient or Dependent(s) ____
(Please note: If signature is for self and dependants, a separate agreement needs signed for self and a separate agreement for dependants)

Please Sign:
Signature of Patient or Parent or Personal Representative: ____
(If younger than 18years of age Legal Guardian to sign)

DATE Signed_________________________________