

**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Have missing teeth ever been replaced by: A bridge _____ RPD _____ Denture _____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? _____

Health History

Child's Physician _____

Physician's Address _____

Physician's Phone Number _____

Date of last physical examination _____ Results _____

Is child under the care of a physician now? _____ Reason _____

Is child receiving any medications or drugs? _____ Reason _____

Is there any excessive bleeding when cut? _____

Has child ever been hospitalized? _____ Reason _____

Has child ever had surgery? _____ Reason _____

Is there any allergy to penicillin or other drugs? _____

Are there other allergies (i.e. food, pollen, animals, dust, other)? _____

Does the child have good physical coordination? _____

Are there any emotional problems? _____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other _____ |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed. _____

In the event your child, under the age of 18 years old, is in our office unaccompanied by an adult, would you please sign the following release form.

I understand that unforeseen treatment is sometimes necessary due to additional decay. If I do not accompany my child to the appointment to discuss possible treatment changes that can occur during the appointment, I give Dr. Perry, Dr. Weigand or Dr. Gurwell permission to provide the treatment that they consider most appropriate at that time. _____ Parent Signature

I also give my permission for the doctor to render indicated and necessary treatment including but not limited to the following (please initial):

1. Take x-rays when indicated _____
2. Utilize nitrous oxide when necessary _____
3. Apply topical fluoride when indicated _____

Signature of parent or guardian _____ Date _____

Signature of Doctor _____ Date _____

SUMMARY (for doctor's use)

YEARLY UPDATE

_____	Parent's Signature _____	Date _____
_____	Parent's Signature _____	Date _____
_____	Parent's Signature _____	Date _____
_____	Parent's Signature _____	Date _____
_____	Parent's 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 _____

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:** _____