

# Patient Registration

How did you hear about our office

*(Please check the appropriate box)*

- Conway Daily Sun     Phone Book  
 Current Patient     Facebook  
 Website     Delta Dental     Other

Who can we thank for referring you:

Emergency Contact

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

## Patient Information

Name

Last: \_\_\_\_\_

First: \_\_\_\_\_

Preferred: \_\_\_\_\_

Status

- Female     Male  
 Single     Married

Personal

Birth date: \_\_\_/\_\_\_/\_\_\_

Social Security #: \_\_\_ - \_\_\_ - \_\_\_

Mailing Address

PO Box/Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address if different  
from Mailing Address:

Email:

\_\_\_\_\_  
*(If you do not want to receive emails  
leave blank)*

Phone

Home: (    ) \_\_\_\_\_

Cell: (    ) \_\_\_\_\_

Work: (    ) \_\_\_\_\_

Ext: \_\_\_\_\_

Employer: \_\_\_\_\_

## Parent/Guardian Information

*(Required if Patient is a minor)*

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_

Personal

Birth date: \_\_\_/\_\_\_/\_\_\_    Social Security #: \_\_\_ - \_\_\_ - \_\_\_

Mailing Address

PO Box/Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone

Home: (    ) \_\_\_\_\_ Work: (    ) \_\_\_\_\_ Ext: (    ) Cell: (    ) \_\_\_\_\_

Today's Date: \_\_\_\_\_

# HEALTH HISTORY

## **MEDICATIONS (ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING)**

**NONE**

- BLOOD THINNERS    ASPIRIN    STEROIDS    ALLERGY MEDS    INSULIN    THYROID MEDS    NSAIDS/IBUPROPHEN  
 HIGH BLOOD PRESSURE MEDS    TRANQUILIZERS    ACID REFLUX MEDS (INCLUDES TUMS, ETC)  
 BISPHOSPHONATES    BIRTH CONTROL    VITAMINS/HERBAL SUPPLEMENTS/NATURAL MEDICATIONS

**HAVE YOU EVER TAKEN:**  FOSOMAX    REDUX    PHEN-FEN    CONTROLLED SUBSTANCES (RECREATIONAL)

OTHER: \_\_\_\_\_

## **ALLERGIES**

**NONE**

- ANITBIOTICS    LATEX    CODEINE    SEDATIVES    ANY METALS    SULFA DRUGS  
 ANESTHETIC (NOVACAIN, LIDOCAIN)    OTHER: \_\_\_\_\_

## **MEDICAL HISTORY (CURRENT OR PRIOR - CIRCLE CHOICE WHERE APPROPRIATE)**

**NONE**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> THYROID DISORDER                     | <input type="checkbox"/> ARTHRITIS                            | <input type="checkbox"/> AIDS/HIV POSITIVE                 |
| <input type="checkbox"/> ANEMIA                               | <input type="checkbox"/> BLEEDING DISORDER                    | <input type="checkbox"/> ASTHMA                            |
| <input type="checkbox"/> SLEEP APNEA/CPAP                     | <input type="checkbox"/> PSYCHIATRIC CARE                     | <input type="checkbox"/> CHRONIC HEADACHES                 |
| <input type="checkbox"/> HEART ATTACK/DISEASE                 | <input type="checkbox"/> ARTIFICIAL VALVE                     | <input type="checkbox"/> CONGENITAL HEART DISORDER         |
| <input type="checkbox"/> PACEMAKER                            | <input type="checkbox"/> MOTOR VEHICLE ACCIDENT - DATE: _____ |  |
| <input type="checkbox"/> STEROID/CORTIZONE TREATMENT          | <input type="checkbox"/> STROKE                               | <input type="checkbox"/> ULCERS (CIRCLE) MOUTH / STOMACH   |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                  | <input type="checkbox"/> HEPATITIS B OR C                     | <input type="checkbox"/> ACID REFLUX                       |
| <input type="checkbox"/> DIABETES TYPE 1 / TYPE 2             | <input type="checkbox"/> EPILEPSY/SEIZURES                    | <input type="checkbox"/> LIVER OR KIDNEY DISEASE           |
| <input type="checkbox"/> CANCER (TYPE) _____                  | <input type="checkbox"/> CHEMOTHERAPY/RADIATION               | <input type="checkbox"/> EMPHYSEMA/COPD                    |
| <input type="checkbox"/> PREGNANT (DUE DATE) _____            | <input type="checkbox"/> ARTICIAL JOINT (WHAT/WHEN) _____     |  |
| <input type="checkbox"/> SURGERIES/HOSPITALIZATIONS _____     |   |  |
| <input type="checkbox"/> OTHER ILLNESS/DISEASE/DISORDER _____ |   |  |
| <input type="checkbox"/> CHEMICAL DEPENDANCY                  | <input type="checkbox"/> TOBACCO USE (CHEW/SMOKE)             | <input type="checkbox"/> ALCOHOL USE (MORE THAN 2 PER DAY) |

## **ORAL HISTORY**

**DO YOU NEED TO PRE-MEDICATE FOR DENTAL TREATMENT**  YES  NO **WITH WHAT:** \_\_\_\_\_

DO YOUR GUMS BLEED WHEN BRUSHING  YES  NO      ARE YOUR TEETH SENSITIVE TO HOT OR COLD  YES  NO

DO YOU FEEL PAIN IN ANY OF YOUR TEETH  YES  NO      DO YOU HAVE ANY SORES/LUMPS IN YOUR MOUTH  YES  NO

DO YOU CLENCH OR GRIND YOUR TEETH  YES  NO      DO YOU HAVE CHRONIC BAD BREATH  YES  NO

JAW/HEAD/TEETH INJURIES (WHAT/WHEN) \_\_\_\_\_

DO YOU EXPERIENCE ANY OF THE FOLLOWING IN YOUR MOUTH/JAW:

- CLICKING    PAIN IN JAW/FACE/EAR    DIFFICULTY CHEWING    DIFFICULTY OPENING/CLOSING

HOW MANY TIMES PER DAY DO YOU BRUSH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS \_\_\_\_\_

DO YOU USE:  ELECTRIC TOOTHBRUSH    WATER PIK    NIGHTGUARD    MI PASTE    FLUORIDE    DRY MOUTH GEL

DO YOU EAT/DRINK MORE THAN ONE SERVING PER DAY OF THE FOLLOWING:

- JUICE    SODA    COFFEE    CANDY    GRANOLA/FRUIT BAR    CITRUS DRINKS    SNACKS  
 CHEWING GUM    COUGH DROPS/LOZENGES

I certify that the above information is correct to the best of my knowledge

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

# OFFICE POLICES

## **APPOINTMENTS**

Your appointment is considered confirmed when you make it. We will try to remind you with a courtesy call, email or postcard in advance.

We understand that circumstances do arise that can keep you from a dental appointment. Please have the courtesy to give the office 48 hours notice. After 2 broken/canceled without 48 hours notice we will no longer be able to reschedule.

## **DENTAL MATERIAL FACTS SHEET**

The New Hampshire Dental Board requires you receive a copy of this form.

## **FINANCIAL**

Our office accepts the following forms of payment: cash, check, Visa, Mastercard, Discover, and American Express. We also offer interest free payments through our finance company, Care Credit. In-house financing is **not** available.

You must provide a Social Security # as well as a valid picture ID at the time of your first visit to protect against identity theft and fraud.

Payment is due at the time of treatment. I understand that my account may be charged a \$10 rebilling fee on balances older than 30 days. I further understand that if my account is not paid within 60 days from date of service, I will be responsible for legal and/or collection agency fees, and any other expenses incurred in collecting my account.

There will be a \$20 charge for all returned checks.

## **INSURANCE**

If you have dental insurance coverage, we will be glad to help you receive your maximum allowable benefits and will file the claim for you as a courtesy.

Information provided by the insurance company is not a guarantee of benefits, only an estimation. Please review your policy book so there are no misunderstandings. If you do not have a policy book, contact your human resource office.

You, the patient, are responsible for your own policy. We are third party billing only, and given minimal information by your insurance company.

**You are responsible for all co-pays at time of service, and any balances that may occur after the insurance has paid. If our efforts to collect insurance payment are unsuccessful, you will be asked to assist us in resolving the problem. If your insurance company has not paid your account in full within 45 days, you will be held responsible for the balance.**

Our goal is to give you the best estimate possible with the information given to us by you and your insurance company. Until the insurance company receives the actual CLAIM, it remains an estimate and is not a guarantee.

Please be aware that few insurance companies attempt to cover all dental costs. Many dental insurance plans set limits for fees or maximum allowable amounts for services which they indicate they will pay 100%. These are referred to as usual and customary fees. If these fees are less than our fees, you will be responsible for the difference. Some insurance companies follow a fee schedule when paying benefits. We do not have access to the details of that fee schedule.

You must notify us to any changes in insurance coverage.

**If you are covered by Healthy Kids Gold, you must notify us of any coverage changes. You WILL be billed IN FULL if your coverage has lapsed.**

## **NOTICE OF PRIVACY PRACTICES**

I have been given and reviewed a copy of the office's Notice of Privacy Practices as required by the Federal Health Insurance Portability and Accountability Act laws.

I have read and understand the above policies. I have been provided with a copy of the Notice of Privacy Practices and the Dental Materials Fact Sheet. All of the information provided by me to your office is accurate to the best of my knowledge.

\_\_\_\_\_  
Signature (Patient/Guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

**Conway Oral Healthcare 51 Washington Street, Conway, NH 03818**

04/11

# DENTAL INSURANCE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## **PRIMARY DENTAL PLAN**

NAME OF SUBSCRIBER: _____				
BIRTH DATE: _____		SOCIAL SECURITY # _____		
ADDRESS: _____				
STREET		CITY	STATE	ZIP
IS THE SUBSCRIBER A PATIENT HERE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
EMPLOYER NAME: _____				
DENTAL PLAN NAME: _____				
SUBSCRIBER ID # _____		GROUP # _____		
RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____				

## **SECONDARY DENTAL PLAN**

NAME OF SUBSCRIBER: _____				
BIRTH DATE: _____		SOCIAL SECURITY # _____		
ADDRESS: _____				
STREET		CITY	STATE	ZIP
IS THE SUBSCRIBER A PATIENT HERE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
EMPLOYER NAME: _____				
DENTAL PLAN NAME: _____				
SUBSCRIBER ID # _____		GROUP # _____		
RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____				

I hereby authorize Dr Hirschfeld to release all information necessary to my insurance carrier(s) to secure payment of benefits. I hereby authorize my insurance carrier(s) to assign directly to Dr Hirschfeld all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Patient/Guardian: _____	Date: _____
Printed Name: _____	
Signature of Primary Insured: _____	Date: _____
Printed Name: _____	
Signature of Secondary Insured: _____	Date: _____
Printed Name: _____	