

Patient Registration

How did you hear about our office

(Please check the appropriate box)

- Conway Daily Sun Phone Book
 Current Patient Family Member
 Internet 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

Patient Name _____ Birth Date _____

MEDICATIONS (Are you currently on any of the following)

NONE

- | | | | | |
|---|--|--|---|----------------------------------|
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Steroids | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> High Blood Pressure Med | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Acid Reflux Meds
(includes Tums, etc) | |
| <input type="checkbox"/> Herbal Supplements | <input type="checkbox"/> Oral/IV Bisphosphonates | <input type="checkbox"/> Birth Control | | |
- Other: _____

Have you ever taken Fosomax Redux Phen-Fen Controlled Substances

ALLERGIES **NONE**

- | | | | | |
|--------------------------------------|-------------------------------------|--|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex | <input type="checkbox"/> Anesthetics (ie Novacain, Lidocain) | <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Any Metals | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Other _____ | |

MEDICAL HISTORY Do you have, or have you ever had any of the following?

NONE

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Cortisone treatments |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Frequent Cough |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Trouble/Disease |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Sinus Problems |

Other Illness: _____

Pregnant, Due Date: _____

Tobacco Use Chew / Smoke Alcohol Use (more than 2 drinks per day)

Physician's Name: _____ Phone: _____

DENTAL HISTORY

Do your gums bleed when brushing Y / N Are your teeth sensitive to hot or cold Y / N

Do you feel pain in any of your teeth? Y / N Do you have any sores/lumps in your mouth Y / N

Have you had any head/neck/jaw injuries Y / N Do you clench or grind your teeth Y / N

Do you have chronic bad breath Y / N

Have you ever experienced any of the following in your jaw?

- Clicking Pain in jaw/face/ear Difficulty chewing Difficulty opening/closing

Do you like the way your teeth look Yes No

Explain: _____

Would you like your teeth to be whiter Yes No

Do you have spaces between your teeth that you would like closed Yes No

Do you have missing teeth that you would like to replace Yes No

If you could change anything about your smile what would you change?

How many times per day do you brush _____ How often do you floss _____

Do you use: Electric Toothbrush ___ Water Pik ___ Nightguard ___ MI Paste ___ Fluoride ___

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

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

08/09

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

DENTAL INSURANCE INFORMATION

Patient's Name: _____ Date of Birth: _____

PRIMARY DENTAL PLAN

Name of Subscriber: _____
Birth Date: _____ Social Security # _____
Address: _____
Street City State Zip Code
Is the Subscriber a patient here? YES NO
Employer Name: _____ City, State: _____
Dental Plan Name: _____
Subscriber ID # _____ Group # _____
Relationship to Patient Self Spouse Child Other _____

SECONDARY DENTAL PLAN

Name of Subscriber: _____
Birth Date: _____ Social Security # _____
Address: _____
Street City State Zip Code
Is the Subscriber a patient here? YES NO
Employer Name: _____ City, State: _____
Dental Plan Name: _____
Subscriber ID # _____ Group # _____
Relationship to Patient Self Spouse Child 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: _____