



Welcome to our practice

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____
 Name _____ Home Phone _____
Last Name First Name Middle Initial
 Address _____ Cell Phone _____
 City _____ State _____ Zip _____ Email _____
 Sex M F Minor Single Married Long Term Partner Divorced Widowed Separated
 Employer _____ Work Phone _____ Occupation _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Preferred Pharmacy _____ Phone Number _____
 Address _____

Office Policies

*I understand that it is my responsibility to notify the office of any changes such as a new address, name change, phone numbers, email address, new insurance, etc.

Patient Signature _____

*I hereby acknowledge that should I need to cancel or reschedule an appointment, I must give the office at least 24 hour notice. **Failure to do so will result in a \$50 cancellation fee.**

Patient Signature _____ Date _____

HIPAA Information

*I hereby acknowledge receipt of HIPAA privacy regulations. *copies available upon request*

Patient Signature _____

***With whom do you authorize us to share your personal dental information?**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Assignment & Release

I hereby authorize payment directly to Reidville Dentistry & Implants for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the release of information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____



Dental History

Former Dentist _____ How often do you brush? _____

City, State _____ How often do you floss? _____

Date of last dental visit _____ Date of last x-rays _____ Date of last cleaning _____

Please check all that apply:

- | | | |
|-------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Blisters on Lips/Mouth | <input type="checkbox"/> Pain Around Ear | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Jaw, Head, or Neck Injury |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Jaw Clicking and/or Pain |
| <input type="checkbox"/> Lip/Cheek Biting | <input type="checkbox"/> Sensitivity to Heat | <input type="checkbox"/> Tooth Pain |

Medical History

Primary Physician's Name _____ Phone # _____ Date of Last Visit _____

Specialist's Name (if needed) _____ Phone # _____

Specialist's Name (if needed) _____ Phone # _____

1. Are you currently under medical supervision? **Y/N**

2. Have you ever had any serious illnesses or operations?.....**Y/N**

3. **Are you currently taking any medications?** **Y/N**

Please list: _____

4. Do you smoke?.....**Y/N**

How much/often? _____

5. Do you drink alcohol?.....**Y/N**

How often? _____

6. **Have you had any allergic reactions to the following:**

Local Anesthetics (eg. novocaine)**Y/N**

Penicillin**Y/N**

Sulfa Drugs**Y/N**

Iodine**Y/N**

Aspirin**Y/N**

Other: _____

7. (Women Only) Are you:

Pregnant?.....**Y/N**

Nursing?.....**Y/N**

Taking Birth Control?....**Y/N**

Please Check All That Apply

- | | | | |
|---------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Cough-Persistent or Bloody | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding Abnormally w.
Extractions or Surgery | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumor/Growth on Head/Neck |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis-Type _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath | |

Reidville Dentistry & Implants LLC

464 Reidville Drive, Suite A2

Waterbury, CT 06705

(203) 575-9120

Method of Payment

Payment is expected on the day service is provided. We will be glad to submit to your insurance company; however, after 90 days if the balance is unpaid, it becomes the responsibility of the patient/insured to follow up with their insurance company.

We accept local (CT) checks, money orders, cash, and major credit cards.

Delinquent accounts transferred to collections will be assessed a fee up to 40% of the unpaid balance.

Returned checks are assessed a minimum fee of \$50.00.

Duplicate Records

Reidville Dentistry & Implants LLC will be glad to forward your records upon your written authorization that should include the name and address of your current dentist.

Radiographs (x-rays) may be forwarded at no charge to another provider. A minimum of five (5) working days is required for this service.

Broken Appointments

Missed appointments are a hardship for everyone, including the patient. Our policy requires 24 hour notice to change or cancel an appointment. Your insurance company is not responsible nor will they be billed for missed appointments. **Appointments broken without 24 hour notice are subject to a \$50.00 charge and may result in the termination of treatment.**

Patient Signature _____ **Date** _____



Reidville Dentistry & Implants LLC

Informed Consent for Routine Dental Treatment

In order to provide comfortable dental treatment it is often necessary to administer local anesthesia (Novocaine, Lidocaine, etc.) by injection. This is a commonly performed procedure in dental offices and usually carries very little risk, however, there are risks associated with its use.

Possible complications include but are not limited to:

- *Local pain and/or infection
- *Temporary but potentially permanent numbness or altered sensation to the nerve that goes to the lip, tongue, gum, etc.
- *Systemic (whole body) reaction including allergic reaction

Additionally, pain or prolonged discomfort to the jaw joints (TMJ) may occur from treatment. This is a known complication due to wide opening and stress on the jaw joints. Although usually temporary, discomfort and restricted jaw movements for some time might occur.

By my signature, I attest that I have read and understand this consent to have local anesthesia administered as necessary and to have routine dental procedures performed. I have provided an accurate history of my medical and dental status including all medications I am taking.

Patient Signature	Print Name (Patient)	Date
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Signature of Guardian (if minor)	Relationship
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Office Staff/Witness

Our Policy Regarding Dental Insurance

If we have received all of your insurance information prior to your appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as ***we will collect from you the estimated amount insurance is not expected to pay on the day treatment is rendered.***

By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 60 days, whether insurance has paid or not.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not pay.

NO INSURANCE PAYS 100% OF ALL PROCEDURES Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage, or the type of contract your employer has set up with the insurance company.

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable, or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules, and each company uses a different set of fees they consider allowable. These allowable fees may vary widely, because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently, this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your dentist is "overcharging", rather than say that they are "underpaying", or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED

When estimating dental benefits, deductibles and percentages must be considered.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

Patient Signature _____ Date _____