# NEW BALTIMORE FAMILY DENTISTRY

*Welcome and Thank you for choosing our practice. Please fill out this form as completely as you can.* (Please Print)

## PATIENT REGISTRATION FORM

PATIENT'S NAME _____ Date of Birth _____
First MI Last

Is Patient: [ ] Male [ ] Female Social Security # _____ Occupation _____

If Patient is a Child, Parent/Guardian's Name _____ Is Child Full Time Student? [ ] Yes [ ] No

Mailing Address _____ City _____ State _____ Zip _____

ACTIVE Contact #'s: Home # _____ Cell # _____ Text Messaging? [ ] Yes [ ] No

Work # _____ EMAIL _____ Other _____

Is Patient: [ ] Minor [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

How were you Referred to our office? _____

Patient's Employer _____ Occupation _____

Name of Spouse _____ Spouse's Date of Birth _____
First MI Last (if different)

In Case of Emergency, Who Should Be Notified _____ Phone _____

If there are any CHANGES in my HEALTH or MEDICATIONS, I will inform the dentist or dental hygienist at my next appointment. If there are CHANGES in INSURANCE information I have provided, I will immediately call the office and update my information, including CHANGES in my ADDRESS, PHONE # or CONTACT INFORMATION. My signature below indicates I understand this policy and will comply.

RESPONSIBLE PARTY (if different than patient) NAME _____
First MI Last

Relationship to Patient: _____ Responsible Party SSN # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

*Please provide* ACTIVE Contact #s: Home _____ Cell _____ Text Messaging? [ ] Yes [ ] No

Work # _____ EMAIL _____ Other _____

## INSURANCE INFORMATION - *Please provide Both Medical and Dental*

MEDICAL INSURANCE:

INSURED/SUBSCRIBER NAME _____ Relationship to Patient _____

MEDICAL INSURANCE CO. _____ MEDICAL INS PHONE # _____

MEDICAL ID /POLICY # _____ GROUP # _____

DENTAL INSURANCE:

INSURED/SUBSCRIBER NAME _____ Relationship to Patient _____

INSURANCE CO. _____ ID /POLICY # _____ GROUP # _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No *If yes, please complete the following:*

INSURED/SUBSCRIBER NAME _____ Relationship to Patient _____

INSURANCE CO. _____ ID /POLICY # _____ GROUP # _____

*XXX (Signature Required)* _____ *DATE* _____

Please Print Signed NAME _____

If Patient is a Minor (under 18yrs); Parent/Guardian hereby grants this practice permission to do any necessary Dental treatment including Xrays/Radiographs.

# NEW BALTIMORE FAMILY DENTISTRY

***Welcome to our practice.*** The doctors, hygienists and staff of this office strive to bring you the optimum in dental care. We participate with, and/or accept the assignment of benefits from, many insurance companies. We work diligently to help you maximize the utilization of your dental benefits and to *estimate any co-pays or out of pocket expenses you may be responsible for.*

***Insurance companies may unfortunately not cover all recommended treatment, Xrays, Composite (tooth-colored) Fillings or other services recommended more frequently than applicable limitations.*** Accurate diagnostic radiographs (X-rays)/and intra oral photographs are REQUIRED for the dental team to properly diagnose and evaluate your dental needs and concerns. Therefore, **we MUST have a digital Panoramic or Full - Mouth Xray present at your FIRST VISIT.** Your insurance company may have a frequency limitation regarding certain radiographs (once every three years is a common time frame with most insurances). If you have had these particular Xrays within the past three years, please contact your prior doctor and **BRING your Xrays with you** to your **FIRST VISIT**, or you may **EMAIL** Xrays to info@nbfdentistry.com or send them by **MAIL** to 12498 Route 9W, West Coxsackie, NY 12192. **We MUST RECEIVE your XRAYS BEFORE you come to your FIRST VISIT** (It is *strongly suggested that you call our office* at 518-731-2797 *BEFORE your first visit to verify that we have received your Xrays*). **If we have NOT received your Xrays or if they are NOT of DIGITAL quality, it will be NECESSARY for our office to take a FULL MOUTH Xray at your FIRST VISIT so we may accurately treat you.** It will be your financial responsibility for any out of pocket expense incurred if your insurance will not cover.

***Amalgam (Silver and Mercury) fillings are NOT used in this office.*** We feel that bonded composite (tooth-colored) fillings provide a superior restoration, both in regards to the health of the tooth and the superior aesthetics they provide. While most insurance plans cover these fillings, ***some may only reimburse you at the rate for Amalgam fillings;*** you will be financially responsible for the difference in what your insurance does not cover. We strive to notify you and provide an ESTIMATE to let you know of any additional co-pay or out of pocket expenses. Topical Fluoride treatments may also be warranted in patients having trouble with caries (cavity) control or in cases of gingival (gum) recession. Often insurance companies may only cover this procedure for minors. These treatment modalities are determined on an individual basis according to a patient's specific requirements. Dental cleanings may also be prescribed more frequently than your insurance company may reimburse. Please ask us if you have any questions regarding your insurance coverage, and remember, it is our goal to help you be informed and to achieve and maintain optimal dental health.

***GENERAL CONSENT TO DIAGNOSE AND TREAT:*** *The undersigned patient and/or their representative hereby authorizes all professionals and affiliates of New Baltimore Family Dentistry LLP to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental condition and needs. I/we authorize all professional affiliates of New Baltimore Family Dentistry LLP to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent to our right to choose and employ such assistance as deemed necessary. I/we understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by professionals of New Baltimore Family Dentistry LLP. To the best of my knowledge, the questions on this and all other forms provided have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my/our responsibility to promptly inform the dental office of any change in medical health, medications, or status including pregnancy.*

***FINANCIAL CONSENT:*** **Our OFFICE FINANCIAL POLICY is PAYMENT is DUE AT TIME of SERVICE.** I/we understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I/we are responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I authorize affiliates of New Baltimore Family Dentistry LLP to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s). If you have Dental Insurance, we will fill out your claim forms and answer any questions we can. Patients with Dental Insurance MUST pay their Deductible and Co-Pays on the day services are rendered. You are responsible for your total obligation should your insurance benefits result in less coverage than anticipated or for services not covered by your insurance company. To the best of our ability we strive to advise you of any out of pocket expense and provide you with an ESTIMATE of that expense. For payment we accept cash, good personal check, Master Card, Visa and CareCredit® (A Health Care Finance Co.- 0% interest for 12 months; please ask for more information) ***Please keep in mind PAYMENT IN FULL MUST BE MADE ON THE DAY SERVICES ARE RENDERED. WE DO NOT HAVE PAYMENT PLANS.***

*XXX (Signature Required)* _____ ***DATE*** _____

**PRINT PATIENT NAME** _____

# Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment may be paid in minimum of two payments or based on the number of appointments to complete treatment.

**Payment options:**
1. Cash
2. Check
3. Visa/MasterCard/Discover/AMEX
4. Lending Club

**Patient with insurance:** The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 90 days, we will bill you directly for the full balance.

**Parents not accompanying their child** to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization). **Parents accompanying their children** are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance.

There is a processing charge for **non-sufficient funds** or returned checks.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **FEE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, _____, agree to these financial terms.

Signature _____ Date_____

New Baltimore Family Dentistry

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications, pills, or drugs? | Yes No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Are you on a special diet? | Yes No | |
| Do you use tobacco? | Yes No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

| | | |
|---|---|---|
| Other? | ☐ | If yes |
| Do you use controlled substances? | Yes No | If yes |

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | Cortisone Medicine | Yes No | Hemophilia | Yes No | Radiation Treatments | Yes No |
| Alzheimer's Disease | Yes No | Diabetes | Yes No | Hepatitis A | Yes No | Recent Weight Loss | Yes No |
| Anaphylaxis | Yes No | Drug Addiction | Yes No | Hepatitis B or C | Yes No | Renal Dialysis | Yes No |
| Anemia | Yes No | Easily Winded | Yes No | Herpes | Yes No | Rheumatic Fever | Yes No |
| Angina | Yes No | Emphysema | Yes No | High Blood Pressure | Yes No | Rheumatism | Yes No |
| Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No | High Cholesterol | Yes No | Scarlet Fever | Yes No |
| Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No | Hives or Rash | Yes No | Shingles | Yes No |
| Artificial Joint | Yes No | Excessive Thirst | Yes No | Hypoglycemia | Yes No | Sickle Cell Disease | Yes No |
| Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No | Sinus Trouble | Yes No |
| Blood Disease | Yes No | Frequent Cough | Yes No | Kidney Problems | Yes No | Spina Bifida | Yes No |
| Blood Transfusion | Yes No | Frequent Diarrhea | Yes No | Leukemia | Yes No | Stomach/Intestinal Disease | Yes No |
| Breathing Problems | Yes No | Frequent Headaches | Yes No | Liver Disease | Yes No | Stroke | Yes No |
| Bruise Easily | Yes No | Genital Herpes | Yes No | Low Blood Pressure | Yes No | Swelling of Limbs | Yes No |
| Cancer | Yes No | Glaucoma | Yes No | Lung Disease | Yes No | Thyroid Disease | Yes No |
| Chemotherapy | Yes No | Hay Fever | Yes No | Mitral Valve Prolapse | Yes No | Tonsillitis | Yes No |
| Chest Pains | Yes No | Heart Attack/Failure | Yes No | Osteoporosis | Yes No | Tuberculosis | Yes No |
| Cold Sores/Fever Blisters | Yes No | Heart Murmur | Yes No | Pain in Jaw Joints | Yes No | Tumors or Growths | Yes No |
| Congenital Heart Disorder | Yes No | Heart Pacemaker | Yes No | Parathyroid Disease | Yes No | Ulcers | Yes No |
| Convulsions | Yes No | Heart Trouble/Disease | Yes No | Psychiatric Care | Yes No | Venereal Disease | Yes No |
| | | | | | | Yellow Jaundice | Yes No |

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

New Baltimore Family Dentistry
12498 US RT 9W
West Coxsackie, NY 12192
518-731-2797

# Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

**PATIENT NAME** _____ **DATE** _____

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

**I understand** that New Baltimore Family Dentistry may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

New Baltimore Family Dentistry has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, New Baltimore Family Dentistry will provide me with the most current *Notice of Privacy Practices.*

**My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow New Baltimore Family Dentistry to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that New Baltimore Family Dentistry has taken action relying on this consent.

**SIGNATURE** (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

**Relationship to Patient** if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: New Baltimore Family Dentistry.

**FORM Us**

# NEW BALTIMORE FAMILY DENTISTRY

## HIPAA CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protection to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgement in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

**PLEASE SELECT ONE** of the following:

☐ Please do not discuss my medical or payment information with anyone.

☐ You may discuss my medical or payment information with the following person or persons:

Name: _____ Phone: _____

Name: _____ Phone: _____

XXX (Signature Required) _____ Date: _____

PLEASE PRINT NAME _____