New Hampshire Family Dentistry

Date: _____ How did you hear about us? _____

Last Name: _____ First Name: _____ Middle Int: _____

Preferred Name: _____

Address: _____City, State, and Zip: _____

Cell phone: _____ Home Phone: _____ Work Phone: _____

Sex: Male _____ Female _____ Marital Status: Married_____ Single _____ Other _____

Birth Date: _____ Social Security Number: _____

E-mail Address: _____

What is the best way to reach you: Cell Phone (Call)___ Text Msg___ Email____

Emergency Contact: _____ Phone #:_____ Relationship: _____

Employment History:

Employment Status: FT ___ PT ___ Retired _____ Occupation: _____

Employer: _____

Are you a Student? FT___ PT ___ Name of School: _____

Is the patient the responsible party? YES __ NO__

Responsible Party (if patient is responsible party, do not fill out this section)

Name: _____ Date of Birth: _____

Address: _____ City, State and Zip: _____

Cell phone: _____ Home Phone: _____ Work Phone: _____

Social security number: _____ Relation to patient: _____

Primary Insurance:

Name of Insured: _____ Date of Birth: _____

Address: _____ City, State and Zip: _____

Cell phone _____ Home Phone: _____Work Phone _____

Insured social security number: _____ Relation to patient: _____

Employer: _____ID number: _____Group #_____

Insurance Company: _____Address: _____

Secondary Insurance:

Name of Insured: _____ Date of Birth: _____

Address: _____ City, State and Zip: _____

Cell phone _____ Home Phone: _____Work Phone _____

Insured social security number: _____ Relation to patient: _____

Employer: _____ID number: _____Group #_____

Insurance Company: _____Address: _____

Insurance & Financial Policy

ACKNOWLEDGEMENT AND RELEASE

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer, and the insurance company.

To provide our patients with dental insurance support, we will:

1. **Do our best to verify insurance benefits**
2. **Provide an ESTIMATE of your co-payment**
3. **Submit your insurance claims and assist you with maximizing insurance benefits**

******ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE. The estimate is based on your insurance benefits, however, each policy is subject to limitations and/or exclusions that we may not be aware of. We encourage you to contact your insurance company if you have questions or concerns regarding your coverage.**

ALL FEES NOT PAID BY INSURANCE ARE YOUR RESPONSIBILITY.

SIGNATURE_____ Date_____

Cancellation Policy

RESTORATIVE AND HYGIENE APPOINTMENTS

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people: the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a $50 fee may be assessed for hygiene appointments and $100 fee may be assessed for doctor appointments.

Note: All cancellation fees must be paid prior to scheduling another appointment.

SIGNATURE_____ Date_____

Oral Health

When were you last seen by a dentist? _____

What was done during the last visit? _____

Reason for today's visit to the dentist: _____

PLEASE SELECT ONE FROM EACH LINE

MY DENTAL HEALTH IS □Excellent □Good □ Fair □ Poor

□ My mouth is very comfortable □ My mouth is moderately comfortable □ My mouth is uncomfortable

□ My smile is excellent □ I would like to change my smile □ I am unconcerned about my smile

□ I will do anything to keep my teeth □ I want to keep my teeth but within a budget of time/money □ I am indifferent

□ I've done the dentistry recommended □ I've NOT done what has been recommended □ Never been recommended

Please check any conditions that apply to you below:

Pain In Jaw (TMJ) __ Teeth Grinding/Clenching __ Use Tobacco Products __

Mouth Sores __ Sensitive Teeth __ Broken/Loose Teeth __

Difficulty Chewing/Swallowing __ Swollen/Bleeding Gums __

Have you ever been treated for periodontal (gum) disease? Yes ___ No____

Have you ever had teeth extracted Yes ___ No____

For what reason?_____

Are you currently wearing Dentures? Yes ___ No____

Age of dentures: Less Than 6 Months __ 6 months__ 3 years __ Greater than 4 years___

Have you ever had an allergic reaction to local anesthetics? Yes ___ No____

Does dental treatment make you nervous? Not at all ___ Slightly ___ Moderately ___ Extremely____

Have you ever had orthodontic treatment (braces)? Yes ___ No____

Do you have a splint, mouthguard or a nightguard? Yes ___ No____ If yes, which one___

How long have you worn one? How often? _____

Medical History

Have you ever had any of the following? Please check those that apply:

*Covid-19 ____ If yes, when? _____

*AIDS ____	*Epilepsy ____	*Mental Disorder ____
*Anemia ____	*Excessive bleeding ____	*Nervous Disorder ____
*Arthritis ____	*Fainting ____	*Pacemaker ____
*Artificial joint /Replacement ____	*Head Injuries ____	*Radiation Treatment ____
*Asthma ____	* HIV ____	
*Blood Disease____	*Hepatitis ____	*Respiratory Problem ____
*Cancer ____	*High Blood Pressure ____	*Sinus Problem ____
*Diabetes ____	*Kidney Disease ____	*Stomach Problem ____
*Dizziness ____	*Latex Allergy ____	*Stroke ____
*Osteoporosis ___	*Liver Disease ____	*Tuberculosis ____
	*Sleep Apnea _____	*Snoring ____

Do you have any drug allergies? _____

For Women: Are you pregnant? _____

Are you under the care of a physician? _____ Date of the last physical examination: _____

Name and phone # of family physician _____

Have you ever had any serious illness or operation? ___Yes ___ No. If yes, describe: _____

Have you ever been hospitalized? ___Yes ___ No. If yes, describe: _____

Do you smoke? ___ Yes __ No - If yes, what & how much? _____Cigars ____ Cigarettes Packs per day =_____

Are you using any recreational drugs? ___Yes ___ No. If yes, what? _____

Do you have any health issues that we should be aware of? _____

Preferred Pharmacy: _____

<u>Please list any medications that you are currently taking</u>:

_____

_____

_____

NEW HAMPSHIRE FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____

_____

_____

New Hampshire Family Dentistry

CONSENT TO DENTAL PHOTOGRAPHY

I, _____, authorize Praveen Mandera D.M.D, to use photographs, and/or videos of my face, jaws, and teeth, taken before, during and after treatment.

I consent to allow the photographs to be used for the following:

• *Dental Records*

• *Dental Research*

• *Dental education including lectures, seminars, demonstrations, and professional publications such as journals or books*

• *Marketing material, including websites, Facebook, Instagram and printed materials, patient education*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

*_____Check here if you DO NOT want your FULL-FACE shot used for any of the above purposes.

*_____Check here if you DO NOT want ANY photos used for the above purposes.

Patient Signature (or parent, if minor): _____

Patient (Print):_____

Date _____