Amherst Dental Group LLP

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial _____

Patient Is: □ Policy Holder
□ Responsible Party

Preferred Name: _____

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial _____
Address: _____ Address 2: _____
City, State, Zip: _____ Home Phone: _____
Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Soc Sec: _____

○ Responsible Party is Also Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
City: _____ State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed
Birth Date: _____ Age: _____ Soc Sec: _____
Email: _____ □ I would like to receive correspondences via email

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Hygienist: _____
Carrier ID: _____ Pref. Pharmacy: _____

Section 3

Emergency Contact: _____
Contact's Phone: _____
Other Address: _____
Other Address 2: _____
Physician: _____
Physician #: _____

Primary Insurance Information

Name of insured: _____ Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____
Address: _____
Address 2: _____
City, State, Zip: _____
Rem. Benefits: _____ Rem. Deductible: _____

Insurance Company: _____
Address: _____
Address 2: _____
City: _____
State, Zip: _____

Secondary Insurance Information

Name of insured: _____ Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____
Address: _____
Address 2: _____
City, State, Zip: _____
Rem. Benefits: _____ Rem. Deductible: _____

Insurance Company: _____
Address: _____
Address 2: _____
City: _____
State, Zip: _____

Amherst Dental Group LLP

MEDICAL HISTORY

NAME: _____ DATE: _____

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

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No _____
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ 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 □ Local Anesthetics
□ Other If yes, please explain: _____

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

□ AIDS/HIV Positive	□ Chest Pains	□ Frequent Headaches	□ Irregular Heartbeat	□ Shingles
□ Alzheimer's Disease	□ Cold Sores/Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Sickle Cell Disease
□ Anaphylaxis	□ Congenial Heart Disorder	□ Glaucoma	□ Leukemia	□ Sinus Trouble
□ Anemia	□ Convulsions	□ Hay Fever	□ Liver Disease	□ Spina Bifida
□ Angina	□ Cortisone Medicine	□ Heart Attack/Failure	□ Low Blood Pressure	□ Stomach/Intestinal
□ Arthritis/Gout	□ Diabetes	□ Heart Murmur	□ Mitral Valve Prolapse	Disease
□ Artificial Heart Valve	□ Drug Addiction	□ Heart Pace Maker	□ Pain in Jaw Joints	□ Stroke
□ Artificial Joint	□ Easily Winded	□ Heart Trouble/Disease	□ Parathyroid Disease	□ Swelling of Limbs
□ Asthma	□ Emphysema	□ Hemophilia	□ Psychiatric Care	□ Thyroid Disease
□ Blood Disease	□ Epilepsy or Seizures	□ Hepatitis A	□ Radiation Treatments	□ Tonsillitis
□ Blood Transfusion	□ Excessive Bleeding	□ Hepatitis B or C	□ Recent Weight Loss	□ Tuberculosis
□ Breathing Problem	□ Excessive Thirst	□ Herpes	□ Renal Dialysis	□ Tumors or Growths
□ Bruise Easily	□ Fainting Spells/ Dizziness	□ High Blood Pressure	□ Rheumatic Fever	□ Ulcers
□ Cancer	□ Frequent Cough	□ Hives or Rash	□ Rheumatism	□ Venereal Disease
□ Chemotherapy	□ Frequent Diarrhea	□ Hypoglycemia	□ Scarlet Fever	□ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain:_____

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 _____ DATE _____

Amherst Dental Group LLP

DENTAL QUESTIONAIRE

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

Approximate date that you were last seen by a dentist: _____ Reason: _____

1. Are you having discomfort at this time? ---------- Y / N

Please check if you are having any of the following concerns with your **teeth**:	
Sensitive to hot	
Sensitive to cold	
Sensitive to sweets	
Sensitive to biting	
Pain upon biting or chewing	
Food impaction or food catch	
Teeth or fillings breaking	
Change or concern with how teeth come together when biting or chewing	
Visible stains / discoloration	
Cosmetic concerns with the appearance of your teeth	

Please check if you have any of the following concerns in your **mouth**:	
Bleeding gums, either spontaneously or while brushing or chewing	
Gums feel irritated, tender or swollen	
Tendency to chew on one side of mouth	
Unpleasant taste / bad breath	
Grinding or clenching of teeth during day or night	
Pain in face / neck muscles / ear/ jaw	
Swelling or lumps present	

2. Have you ever had any serious injury to your head or jaw? ---------- Y / N
3. Do you avoid any part of your mouth when you brush? ---------- Y / N

Please check if you use the following:			
Manual toothbrush		Dental floss	
Electric toothbrush		Mouthwash	
Fluoride rinse		Other (proxy brush, rubber tip, water pic, etc)	

4. Have you ever lost any of your teeth (excluding baby teeth)? ---------- Y / N
5. Have you ever had any problems with extractions? ---------- Y / N
6. Have you ever had any special dental work done (i.e braces, periodontal surgery, etc)? ---------- Y / N
7. Have you had any bad dental experiences in the past? ---------- Y / N
8. Do you have any other questions or comments?

_____

_____

_____

_____

_____

Amherst Dental Group LLP

Written Financial Policy

Thank you for choosing Amherst Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card

We offer a 5% courtesy accounting adjustment (10% for patients over 60) for the payment of treatment with check, credit card or cash at beginning of care.

- NO INTEREST[1] Payment Plans[2] from CareCredit

  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

Amherst Dental Group requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

Insurance:

Our business office will submit primary and secondary insurance claims for you-subject to your having given us current information prior to the service being provided. Policy coverage varies from one plan to another, as do the "usual, customary and reasonable" fees that various insurance plans have established. Our fees are accepted by most plans, but occasionally one of our patients is notified that the amount for our service exceeds "UCR FEES". Our contractual arrangement is with you, our patient, not your insurance company. We will do our best to maximize your insurance benefits, however should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute with your insurance carrier is between you and your insurance carrier. The final responsibility for the services provided to you is yours.

- A fee of $50-150 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.
- Amherst Dental Group charges $30 for returned checks.
- If previous arrangements have *not* been made with our office, any account balance outstanding longer than 28 days will be charged a $10 re-bill fee for each 28-day cycle.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Amherst Dental Group LLP

Patient Name: _____

PART I

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I have received or was offered a copy of this office's Notice of Privacy Practices. _____ (please initial)

PART II

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

1. I, _____, authorize Amherst Dental Group to use and/or disclose my protected health information for the purposes of treatment, payment and/or heath care operations to the person(s) listed below:

Name of Authorized Person: _____

Relationship to Self: _____

Name of Authorized Person: _____

Relationship to Self: _____

□Check this box if you do not authorize the use and/or disclosure of protected health information

2. I understand that this consent can be cancelled at any time and is optional. A signed consent can be delivered in person or mailed to the address listed above, and will become effective upon receipt.

3. I understand that disclosing information to someone who is not required to comply with the federal privacy protection regulations may result in re-disclosed information.

My signature certifies that I authorize Amherst Dental Group to disclose my health information to the above listed person(s) to the extent necessary to help with my healthcare or with payment for my healthcare.

X_____

Signature Date

_____

Print Name

Amherst Dental Group LLP

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the options of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the possibility of occurrence.

It is very important that you provide your dentist with accurate information (including changes in general health, medications, etc.) before, during, and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Dentistry is not an exact science. Although every effort will be made to optimize treatment results, reputable practitioners cannot properly guarantee results.

Please read the items below and sign at the bottom of the form.

1. **Treatment to be Provided**
   I understand that during my course of treatment the following care may be provided:
   - Examinations – including x-rays and intraoral pictures
   - Preventative services – including sealants and dental prophylaxis
   - Restorations – fillings, inlays, onlays, veneers
   - Crowns and bridges
   - Root Canal Therapy
   - Dental surgery procedures – incision and drainage, routine and surgical extractions
   - Removable appliances – flippers, occlusal guards, full and partial dentures
   - Restoration of dental implants
2. **Drugs and Medications**
   I understand that antibiotics, analgesics, antiseptics, local anesthetics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Local anesthetics can cause numbness or tingling of the lip, chin, face, mouth, teeth and tongue, and changes in taste sensation; which is usually temporary but in rare cases may be permanent.
3. **Treatment Complications**
   I understand that treatment complications may necessitate additional medical, dental, or surgical treatment; and may require additional periods of recuperation at home or in the hospital.
4. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
5. I give permission to the dental office to bill my insurance provider for the treatment provided, if applicable.

_____ _____

Patient Signature Date