

Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Patient and Family Information

Child's Name _____ Birthdate _____ ☐Male ☐Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type _____ ☐ Tuberculosis

☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other _____

☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever _____

☐ Cancer ☐ Heart Murmur ☐ Tonsillitis _____

Primary Dental Insurance



Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance



Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

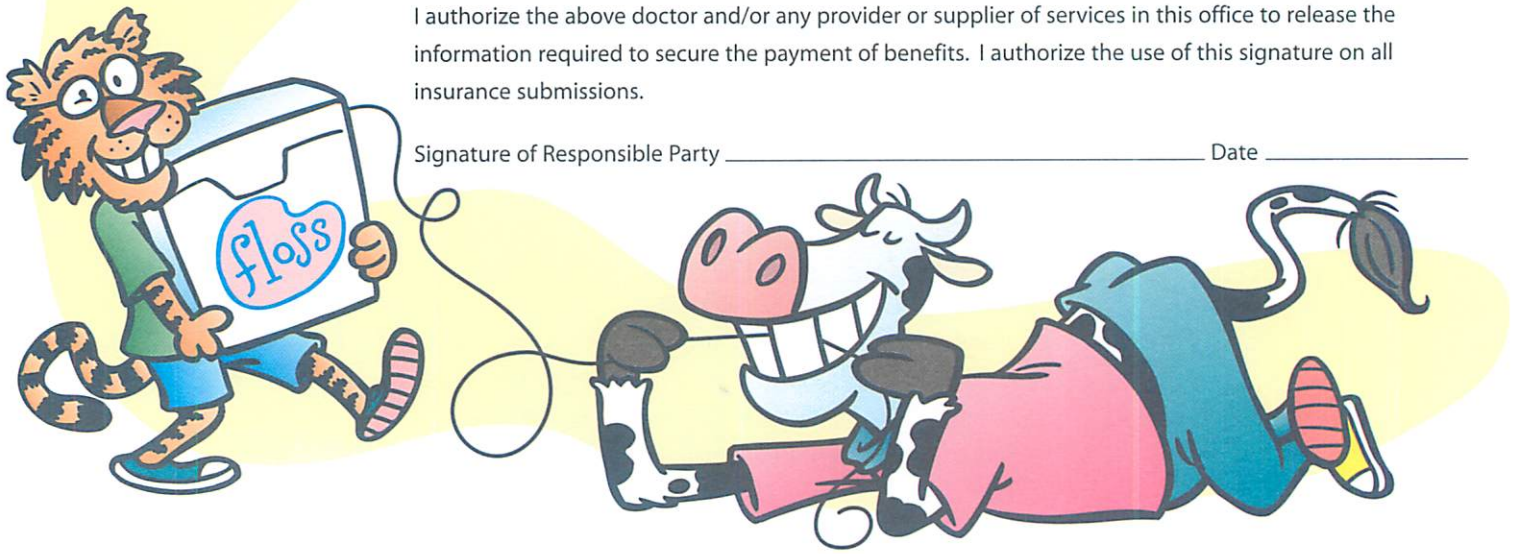
Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____ 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 above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____



Dental Associates of Rockville, LLC
50 Hale Street
Rockville, CT 06066

OFFICE AND FINANCIAL POLICY:

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, and Visa. Returned checks and account balances older than 90 days may be subject to additional collection fees. All collection costs, court costs, and attorney's fees will be your responsibility.

Charges may also be made for broken appointments. We must have 48 hours (2 days) notice of cancellation of appointments. If we do not have the required 48-hour cancellation notice, you may be charged a "No Show" fee of $50-150 (depending on service type). Patients that miss two or more appointments without calling to cancel/change their appointment will be discharged/dismissed from our practice. We currently have a waiting list of patients for appointments. If you cannot make your appointment, please notify us so we can give someone else that appointment time. Frequent missed appointments have a huge impact on our ability to see and treat our patients and cannot be overlooked.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts.
We must emphasize that as dental care providers, our relationship is with you, not your insurance company.
While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered, as well as any costs incurred for collection.

_____ _____
Patient's signature Date

AUTHORIZATION TO PAY BENEFITS AND TO RELEASE INFORMATION

I hereby authorize payment directly to the above name dentist of the dental benefits otherwise payable to me. I hereby authorize the above-named dentist to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

_____ _____
Patient's signature Date

Dental Associates of Rockville, L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone #: _____ Social Security# _____

Consent for Use and Disclosure of Health Information

Authorization: I authorize Dental Associates of Rockville, L.L.C. to use or disclose the following: (check one)

☐ - All of my health information.

☐ - My health information ONLY related to: _____

☐ - My health information from (dates) _____ to _____

☐ - Not Applicable

Disclosure: Dental Associates of Rockville, L.L.C. can disclose my health records per the above selected conditions to:

Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Email: _____

Please read the following statements carefully

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You consent to our disclosure of your protected health information all or in part to the party listed above. You also authorize insurance payment directly to this office.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy is available for you and we encourage you to read it carefully.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our contact person. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations; and to the party I listed in the disclosure section of this document.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ **Date:** _____

Relationship to Patient: _____