PISCATAQUA
DENTAL PARTNERS
288 Lafayette Road, Bldg. A, Portsmouth, NH 03801 TEL (603)431-4559 FAX (603)431-7560

PATIENT FIRST NAME: _____MI____LAST NAME_____DOB: ____/____/_____

PLEASE COMPLETE ALL INFORMATION – THANK YOU **____New Patient** **____Returning Patient**

PATIENT DEMOGRAPHICS

Nickname_____SS# _____/_____/_____ Married____Single____Divorced___Widowed___ Male____Female____

Mailing Address_____ Unit # _____ City_____ State_____ Zip_____

Home Phone ( )_____Mobile Phone ( )_____ Work Phone ( )_____

Email_____ Spouse's Name_____

ACCOUNT INFORMATION – Subscriber to Insurance

PERSON WHO SUBSCRIBES TO THE INSURANCE_____EMPLOYER_____

RELATIONSHIP TO THE PATIENT_____

Date of Birth_____/_____/_____SS# _____/_____/_____

Mailing Address_____ Unit # _____ City_____ State_____ Zip_____

Home Phone ( )_____Mobile Phone ( )_____ Work Phone ( )_____

DENTAL INSURANCE INFORMATION – Please provide insurance card, if available

Primary Insurance Name _____Phone Number ( )_____

Group # _____ Subscriber #_____

Address_____ Unit # _____ City_____ State_____ Zip_____

**Secondary Insurance (if applicable)_____Grp#_____Sub#_____

RESPONSIBLE PARTY – If patient is a minor

RELATIONSHIP TO THE PATIENT_____

Date of Birth_____/_____/_____SS# _____/_____/_____ Married____Single____Divorced___Widowed___ Male____Female____

Mailing Address (IF DIFFERENT)_____Unit # _____ City_____ State_____ Zip_____

Home Phone ( )_____Mobile Phone ( )_____ Work Phone ( )_____

I agree to be responsible for payment of all services rendered on my behalf concerning mine (or my child's) dental care. I understand that payment is due at time of treatment unless prior arrangements have been made. All accounts must be paid within 30 days. In the event that your account becomes delinquent, finance charges will accrue and the patient is responsible for all collections fees. At Piscataqua Dental we have a mandatory 48 hour cancellation notice. A fee of $100.00 will be charged for all failed Doctor Appointments and $50.00 for all failed Hygiene Appointments cancelled without proper 48 hour notice.

PATIENT/GUARDIAN SIGNATURE _____ **DATE**_____/_____/_____

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PATIENT NAME: _____DOB: _____/_____/_____

PLEASE COMPLETE ALL INFORMATION – THANK YOU

MEDICAL HISTORY

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.

GENERAL

Are you under a physician's care? ☐Yes ☐No If yes, please explain: _____

Have you been hospitalized or visited the emergency room in the last 6 months? ☐Yes ☐No

If yes, what were you treated for? _____

Are you currently taking blood thinners? ☐Yes ☐No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No

If yes, please explain: _____

ALLERGIES

Allergies -- Please circle all that apply: Aspirin Erythromycin Metals Latex Sulfa Codeine Dental Anesthetics Amoxicillin Penicillin Tetracycline

Please list any additional allergies: _____

HABITS – Amounts

☐ Smoke _____Packs ☐ Alcohol _____ Per Day/Week/Month

☐ Drug Use _____ Have you ever had a problem with drugs or alcohol? ☐Yes ☐No

Other _____

MEDICATIONS

Do you require pre-medication? (please circle) Yes or No If yes, which medication? _____

Please list all medications you are now taking and for which condition:

Medication Dosage Purpose

_____
_____
_____
_____
_____
_____
_____
_____
_____

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CONDITIONS

Y /N (Please check below)	Y /N (Please check below)	Y /N (Please check below)	Y /N (Please check below)
SKIN	**CARDIOVASCULAR**	**MUSCULOSKELETAL**	**DEVELOPMENTAL**
☐☐ Bruise easily	☐☐ Mitral Valve Prolapse	☐☐ Artificial Joints	☐☐ Autism
☐☐ Rashes/Hives	☐☐ Rheumatic Fever	☐☐ Broken Bones	☐☐ Disabilities
EYES	☐☐ Any Heart Disease	**DIGESTIVE**	☐☐ Cerebral Palsy
☐☐ Glaucoma	☐☐ High Blood Pressure	☐☐ Heartburn	**OTHER**
EARS	☐☐ Low Blood Pressure	☐☐ Stomach Ulcers	☐☐ Cancer
☐☐ Loss of Hearing	☐☐ Congenital Heart Disease	☐☐ Liver Disease	☐☐ Tuberculosis
☐☐ Ear Infections	☐☐ Pacemaker	☐☐ Intestinal Disease	☐☐ Auto-Immune Disease
NOSE	☐☐ Scarlet Fever	**URINARY**	☐☐ Radiation Treatment
☐☐ Sinus Problems	☐☐ Heart Murmur	☐☐ Kidney Disease	☐☐ Tumors/Growths
☐☐ Frequent Nose Bleeds	☐☐ Heart Surgery	☐☐ Kidney Transplant	☐☐ Herpes
THROAT	☐☐ Irregular Heartbeat	☐☐ Renal Dialysis	ENDOCRINE
☐☐ Frequent Sore Throat	**NERVOUS SYSTEM**	**BLOOD**	☐☐ Hypoglycemia
☐☐ Post Nasal Drip	☐☐ Stroke	☐☐ Blood Disorders	☐☐ Thyroid Problems
RESPIRATORY	☐☐ Frequent Headaches	☐☐ Anemia	☐☐ Diabetes
☐☐ Asthma	☐☐ Convulsions/Epilepsy	☐☐ HIV	**(If you marked *yes to diabetes)***
☐☐ Emphysema	☐☐ Numbness/Tingling	☐☐ Hepatitis	Type 1 ☐ or Type 2 ☐
☐☐ Lung Disease	☐☐ Dizziness/Fainting	☐☐ Sickle Cell	***Have you checked your blood sugar today?***
☐☐ Persistent Cough	☐☐ Psychiatric Treatment		Yes ☐ No ☐

All Operations or Surgeries Year

_____

_____

_____

_____

Is there anything else you feel we should know about?

_____

_____

_____

WOMEN ONLY: ***Are You:***

Pregnant/Trying to get Pregnant? ☐Yes ☐No *Taking oral contraceptives?* ☐Yes ☐No *Nursing?* ☐Yes ☐No

IMPORTANT: Antibiotics (Penicillin, Erythromycin, etc.) which may be prescribed after treatments, may cause the birth control pill to be ineffective. Other methods of contraception are recommended for the duration of the effected cycle.

AUTHORIZATION AND RELEASE

I certify that I can speak, read, and write English and have read and fully understand this medical history form. To the best of my knowledge all the preceding answers are true and correct:

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

PROVIDER SIGNATURE_____ **DATE**_____

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Financial Agreement

We thank you for selecting us as your dental provider and consider it a privilege to serve your needs. Our staff is committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to the provider-patient relationship. Our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding fees, policies, or responsibilities please contact our office at 603.431.4559.

Payments & Interest

Payment is due upon service unless a payment arrangement has been approved in advance by our staff.

We make payments as convenient as possible by accepting (cash, money orders, MasterCard, Visa, Discover, American Express, checks, and Care Credit). A $10.00 fee will be charged for all returned checks and interest will incur if a balance remains unpaid after 30 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have learned that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at time of service, unless otherwise approved with our staff.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any changes when they occur. Preauthorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. When insurance is involved, we are contractually obligated to collect co-payments, co –insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out of network fees.

Missed Appointments

We require notice of cancelations 48 hours in advance. This allows us to offer the appointment time to another patient. If you fail to keep your scheduled appointment without notifying us in advance, a missed appointment fee will apply. These fees are $50.00 for missed hygiene appointments and $100.00 for missed doctor appointments. Repeated missed appointments without notification may cause you to be discharged from the practice.

We try to see everyone in a timely manner but if we are taking too long, please let us know so that we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy and I agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

PATIENT/GUARDIAN SIGNATURE _____ **DATE**_____

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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.

_____

PATIENT/GUARDIAN SIGNATURE

_____

DATE

_____

For Office Use Below

_____

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 barrier prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Specify)_____

Piscataqua Dental Partners, PA
Nellita M. Manley, DDS
Lora Selle, DMD
Molly H. Valli, DMD

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Phone (603) 431-4559 Fax (603) 431-7560

General Dental Release

Please provide me with copies of all of my dental records and x-rays pertaining to my dental treatment. I understand that the information contained in the record belongs to me. I agree to accept copies of such records.

Previous Office Name: _____

Address: _____

Telephone: _____

Fax: _____

Please forward these records to:

Piscataqua Dental Partners
288 Lafayette Rd Bldg A
Portsmouth, NH 03801

X-Rays can be emailed to xrays@piscataquadental.com

Patient Name:_____

Patient Signature:_____Date:_____

Date of Birth: _____