Drew DENTAL GROUP

NEW PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name: _____ Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Other _____

Patient Information

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Birth Date: ___/___/___ Age: _____ Soc Sec: _____

Occupation: _____ Place of Employment: _____

E-Mail: _____ Preferred Method of Contact: ❑ Email ❑ Text ❑ Phone

Emergency Contact:

First Name: _____ Last Name: _____ Phone: _____

Address: _____

Have you been a patient in any of our offices before? ❑ Yes ❑ No Have any of your family members? ❑ Yes ❑ No

Who may we thank for referring you to our office? _____

Primary Insurance Information

Policy Holder: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy Holder Soc. Sec / ID #: _____ Policy Holder Birth Date: ___/___/___

Employer: _____ Ins. Company: _____

Secondary Insurance Information

Policy Holder: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy Holder Soc. Sec / ID #: _____ Policy Holder Birth Date: ___/___/___

Employer: _____ Ins. Company: _____

Responsible Party (if other than patient)

First Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: ___/___/___ Soc Sec: _____ Driver's Lic: _____

Occupation: _____ Place of Employment: _____

Patient's Name: _____ MEDICAL HISTORY

Although dental personnel primarily treat in and around your mouth, your mouth is a part of your entire body. Health problems 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 answering the following questions.

MEDICAL HISTORY

Are you allergic to any of the following?

Primary Care Physician _____

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

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

Do you pre-medicate before dental appointments? _____

- ☐ Acid Reflux/GERD
- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Allergic Reactions
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Depression
- ☐ Diabetes
  - A1C _____
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema/COPD
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Issues
  - Please list _____
- ☐ Hemophilia
- ☐ Hepatitis A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

Have you ever had any illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A Name of Doctor or Specialist _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A _____

Have you ever had a serious neck or head injury? ☐ Yes ☐ No ☐ N/A _____

Are you taking any medications, pills, or drugs or over the counter vitamins/supplements? ☐ Yes ☐ No ☐ N/A

Please list: _____

_____

Are you or have you ever taken Bisphosphonate medications (Fosamax, Boniva, Reclast, Zometa, Actonel or other)? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No (Please specify cigarette, cigars, chewing tobacco, vape) _____

Do you use recreational drugs? ☐ Yes ☐ No (Please specify for example: Marijuana, Cocaine, Methamphetamines or other) _____

Do you use controlled substances? ☐ Yes ☐ No ☐ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Has anyone in your family had diabetes, cardio, pulmonary or periodontal conditions? (Specify) _____

DENTAL HISTORY

Check all that apply:

Preferred Pharmacy _____

- ☐ Bad Breath
- ☐ Bad Taste
- ☐ Biting Pain
- ☐ Bleeding Gums
- ☐ Chipped Teeth
- ☐ Clicking/Jaw Pain
- ☐ Dentures/Partials
- ☐ Difficulty Opening/Closing
- ☐ Dry Mouth
- ☐ Grinding/Clenching Teeth
- ☐ Head/Neck/Jaw Injuries
- ☐ Loose Teeth
- ☐ Lumps/Sores in/near Mouth
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Recent Mouth Trauma
- ☐ Sensitive to Hot/Cold
- ☐ Sensitive to Sweets
- ☐ Sleep Apnea Device
- ☐ Other: _____

What is the primary reason for your visit today? _____

Are you having pain or discomfort at this time? ☐ Yes ☐ No _____

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No _____

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

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 employment, or insurance status.

Signature of Patient (or Guardian) _____ Date: ___/___/___

OFFICE POLICIES & FINANCIAL AGREEMENT

Thank you for putting your trust in Drew Dental Group. Your oral health is our primary concern, and we are committed to providing our patients the best care possible in a comfortable and caring environment.

Our financial policy does require payment in full at the time services are provided. We do accept assignment of benefits for most major insurance policies. Please understand that your account must be kept current throughout treatment. The following is a statement of our Financial Policy which we require you to read, agree to, and sign before any treatment.

PAYMENT OPTIONS

*Cash/Check
*Visa, MasterCard, American Express, and Discover Cards
*CareCredit®

Payment plans are available up to 12 months with no interest on charges over $300. Extended payment plans beyond 12 months are also available. We will be happy to provide you with their information if you would like to apply for a line of credit.

INSURANCE

Please read and sign separate Insurance Policies form

****Our team is available to assist you in understanding your benefits and filing the necessary paperwork****

PAST DUE ACCOUNTS

Accounts without acceptable payment activity for 60 days will be considered past due. A billing charge may be added to your account in addition to the original account balance.

COLLECTIONS

Accounts without acceptable payment activity for 90 days will incur a collections fee of 15% in addition to your current balance. If this becomes necessary, your account will be placed with an outside collection agency and you will not receive any further account notifications from our office.

CANCELLATIONS

If you have scheduled an appointment with the Doctor or Hygienist and need to cancel or reschedule, a minimum of 24 hours notice is required. If you fail to provide adequate notice, we reserve the right to cancel your appointment or bill you $50 for the appointment you had reserved.

MINORS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will not be performed, unless prior payment has been made or charges have been authorized by the parent or legal guardian to a valid credit card accepted by our office.

PHOTOGRAPHS

I give my permission to Drew Dental Group or any representative they may designate, to photograph me for diagnostic purpose and to enhance the medical record. I agree that these photographs will remain Drew Dental Group's property (this includes all diagnostic x-rays). I further authorize Drew Dental Group to use these photographs for teaching purposes, to illustrate scientific papers, for use in lectures. If any photographs are used for any reason I shall not be identified by name.

SIGNATURE RELEASE

I authorize the releases of dental/medical information necessary to either process my insurance claims for treatment performed by Drew Dental Group, or when necessary, to other providers rendering medical/ dental care. I assign all dental/ medical/ surgical benefits for treatment performed by Drew Dental Group to which I am entitled to be paid to Drew Dental Group. This assignment will remain in effect until revoked by me **in writing**. A copy of this assignment is to be considered as valid as the original.

_____ _____

PATIENT'S SIGNATURE (Parent if Minor) DATE

_____

PATIENT'S NAME (Please Print)

****All patients are required to sign an updated financial agreement every year****

INSURANCE POLICIES AGREEMENT

There are many complexities with dental insurance. Our financial policy requires payment in full at the time services are provided. We do accept assignment of benefits for most major insurance policies. **Please understand that your account must be kept current throughout treatment.**

If your plan provides benefits for services in our office, you will be asked to leave the anticipated co-pay at each visit. **THIS IS ONLY AN ESTIMATE.** We will file insurance claims and submit the information necessary for your insurance company to process those claims. This is a service we provide as a courtesy to our patients, but please understand you have the contract with the insurance company and ultimately are responsible for payment. If services are listed by your insurance company as "NON-COVERED BENEFITS", we will not be sending claims for those services and they will be your responsibility. This also applies when you have maximized your insurance and there are no benefits to claim. The insurance industry is a conglomeration of companies with many different policies. Those policies all have different insuring agreements, exclusions and conditions. **We will not guarantee a payment will be made from your insurance company**, nor will we make a settlement on a disputed claim. We will not disclose this information to any dental plan during an audit unless you agree in writing.

Our practice is committed to providing the best treatment possible to our patients. You are responsible for the cost of treatment provided regardless of an insurance company's arbitrary determination of the "allowable" fees. Once a claim is paid, the remaining balance is the responsibility of the guarantor, regardless of the estimate.

Remember, you are the holder of the contract. It is your responsibility to ensure you understand the contract between you and your insurance company and to know the benefits available under your policy. If after 60 days your insurance company has not rendered payment the balance will become your responsibility.

_____ _____

PATIENT'S SIGNATURE (Parent if Minor) DATE

_____

PATIENT'S NAME (Please Print)

****Our team is available to assist you in understanding your benefits and filing the necessary dental insurance paperwork.****

256 Boston Post Rd, Waterford, CT 06385 (860) 443.0861 www.raccioanddrewdental.com

Drew DENTAL GROUP

John R. Drew DMD

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 Name (Please Print)

_____

Patient, Parent or Guardian Signature

_____

Date

For Office Use Only

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

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

Drew DENTAL GROUP

John R. Drew DMD

PATIENT'S RECORD RELEASE

This is full and sufficient authorization to release to Drew Dental Group at 256 Boston Post Road, Waterford, CT 06385 any and all dental records including x-rays for the following patient.

Patient Name: _____

Date of Birth: _____/_____/_____

Previous Dentist Name and Address: _____

_____

_____

_____

Patient Signature (or authorized representative)

_____

Patient Name (print)

_____

Date

Address where records should be released:

Email: **frontdesk@raccioanddrewdental.com**

DREW DENTAL GROUP
256 BOSTON POST ROAD
WATERFORD, CT 06385

Drew Dental Group

NOTICE OF PRIVACY PRACTICES

This Notice describes how health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 31, 2012, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION -We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use or disclose your health information in connection with our health care operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health Related Services: We will **not** use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public benefit: We may use or disclose your health information to report, abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA) to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials any health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge a reasonable cost-based fee for the cost of supplies and the labor of copying. If you request copies, we will charge you $.45 for each page, and $15.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than, treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April, 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: you may receive a paper copy of this notice upon request, even if you have agreed to receive the notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or to alter locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.