



**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 ____/____/____

New: 05/24/2018

PATIENT REGISTRATION



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CONDITIONS

Y /N (Please check below)

SKIN

- Bruise easily
- Rashes/Hives

EYES

- Glaucoma

EARS

- Loss of Hearing
- Ear Infections

NOSE

- Sinus Problems
- Frequent Nose Bleeds

THROAT

- Frequent Sore Throat
- Post Nasal Drip

RESPIRATORY

- Asthma
- Emphysema
- Lung Disease
- Persistent Cough

Y /N (Please check below)

CARDIOVASCULAR

- Mitral Valve Prolapse
- Rheumatic Fever
- Any Heart Disease
- High Blood Pressure
- Low Blood Pressure
- Congenital Heart Disease
- Pacemaker
- Scarlet Fever
- Heart Murmur
- Heart Surgery
- Irregular Heartbeat

NERVOUS SYSTEM

- Stroke
- Frequent Headaches
- Convulsions/Epilepsy
- Numbness/Tingling
- Dizziness/Fainting
- Psychiatric Treatment

Y /N (Please check below)

MUSCULOSKELETAL

- Artificial Joints
- Broken Bones

DIGESTIVE

- Heartburn
- Stomach Ulcers
- Liver Disease
- Intestinal Disease

URINARY

- Kidney Disease
- Kidney Transplant
- Renal Dialysis

BLOOD

- Blood Disorders
- Anemia
- HIV
- Hepatitis
- Sickle Cell

Y /N (Please check below)

DEVELOPMENTAL

- Autism
- Disabilities
- Cerebral Palsy

OTHER

- Cancer
 - Tuberculosis
 - Auto-Immune Disease
 - Radiation Treatment
 - Tumors/Growths
 - Herpes
- ENDOCRINE**
- Hypoglycemia
 - Thyroid Problems
 - Diabetes

(If you marked yes to diabetes)

Type 1 or Type 2

Have you checked your blood sugar today?

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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