DeMartin Dental Associates

(REV.7/21)

69 SHERMAN ST., FAIRFIELD, CT 06824 ~ PH. #203-255-0468

DATE_____

NAME_____
Last First Middle Initial

Address_____
Street

City_____ **State**_____ **Zip**_____

Home Ph._____ **Cell Ph.**_____

Work Ph._____ **E-mail**_____

***CONFIRM APPOINTMENTS TO: ☐ Home ☐ Call Cell ☐ Work ☐ Text to Cell/Email

Date of Birth _____ **Sex**_____ **Social Security#**_____

Emergency Contact
Name:_____ **Phone:**_____

***Referred by**:_____ Previous Dentist:_____

1. Were you **hospitalized/or under the care of a physician** (not checkups) in the last 2 years **YES NO**
   If yes, please explain_____
2. **Have you had a serious illness or operation recently?** **YES NO**
   If yes, please explain_____
3. **Name of physician**_____
4. **Have you ever had excessive bleeding requiring special treatment** **YES NO**
5. **Have you ever been advised to PRE-MEDICATE prior to dental procedures** **YES NO**
   WHY? Joint Replacement_____ **Heart**_____ **OTHER**_____
6. **Do you use Tobacco/Vaping?** _____ **YES NO**
7. **Are you pregnant or possibly pregnant** **YES NO**

Are you allergic to or have you reacted adversely to:

Penicillin/Amoxicillin or other antibiotics? Specify_____ **YES NO**
Codeine or other narcotics? **YES NO**
Dental anesthetic (Novocaine, Lidocaine, Carbocaine, Xylocaine, Latex gloves etc.) **YES NO**
Food allergy? Specify _____ **YES NO**

Are you taking any of the following?

☐ Aspirin or aspirin like drugs
☐ Anticoagulant (Blood thinners)
☐ High blood pressure Medications
☐ Steroids (cortisone, prednisone)
☐ Cancer Therapy Medications
☐ Sedatives or sleeping pills
☐ Osteoporosis medications
☐ Antihistamines
☐ Oral contraceptives
☐ Hormone pills
☐ Anticonvulsive drugs
☐ Insulin, Orinase or similar blood sugar drugs
☐ Other Medications_____
☐ Non-prescription medications_____
☐ Heart Medications
☐ Nitroglycerine
☐ Antibiotic/Sulfa drugs
☐ Synthroid/Thyroid drugs

Check any of the following which you have or have had:

☐ Heart trouble
☐ High Cholesterol
☐ Congenital heart lesions
☐ Cardiac pacemaker
☐ Heart murmur
☐ Prolapsed mitral valve
☐ Anemia
☐ Rheumatic fever
☐ Asthma
☐ Osteoporosis
☐ Diabetes
☐ Tuberculosis
☐ Arthritis
☐ Jaundice
☐ Liver problems
☐ Artificial heart valves
☐ Epilepsy/seizures
☐ Joint replacement
☐ Sinus trouble
☐ Cancer treatment
☐ Psychiatric treatments
☐ Stroke
☐ High/Low blood pressure
☐ Clotting problems/ bleeding disorders
☐ Blood disease
☐ Kidney problems
☐ Thyroid disease
☐ Hepatitis
☐ HIV+
☐ Auto-immune

***Do you have Dental Insurance? Yes _____ No _____**

*** TURN OVER →

DEMARTIN DENTAL ASSOCIATES, P.C. FINANCIAL AGREEMENT

DeMartin Dental Associates expects payment in full when services are rendered **unless other arrangements are made in advance.** For your convenience, we accept cash, checks, American Express, Discover, MasterCard and Visa. We also offer financing options through a third-party financing institution. Please feel free to discuss billing arrangements with our Business Office. We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. There is a fee (currently $30.00) for any checks returned by the bank. **In cases that require extensive laboratory services or involve long treatment times, a deposit is required.**

INSURANCE: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. It is your responsibility to meet any requirements for x-rays or other information mandated by your insurance company for processing purposes. We will provide you with any information necessary for dealing with workman's compensation or personal injury – however you are responsible to pay for treatment at the time it is rendered.

FINANCE/BILLING CHARGE: A finance charge may be imposed on each item of your account which has not been paid within thirty (30) days of the time the service was rendered. The FINANCE CHARGE will be computed at the rate of one and one-quarter percent (1 1/4%) per month or an ANNUAL PERCENTAGE RATE of fifteen (15%) percent. The finance charge on your account is computed by applying the periodic rate (1 1/4%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $1.00. If the account balance remains outstanding after 90 days, a billing charge of $50 may be applied to the account on a monthly basis.

MISSED APPOINTMENT FEE: Patients may be charged a fee of $100 for a missed appointment if not cancelled at least 24 hours in advance.

COLLECTION AND WAIVER OF CONFIDENTIALITY: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency/lawyer, you agree to pay **all** of the collection costs which are incurred. You understand if this account is submitted to any attorney or collection agency, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

DIVORCE INVOLVING A MINOR: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Parent/Guardian (if pt is a minor/guardianship)_____Relationship :_____

Address:_____ Home Phone:_____

Employer:_____ Work Phone:_____

Social Security Number:_____ Date of Birth:_____

PRIMARY Dental Insurance Information:

Insurance Company_____ Insured ID#:_____

Group#_____ **Employer's Name**:_____

Name of Insured Employee if other than self_____

Relationship to Pt _____

Insured's: Address _____

Insured's Contact Phone _____ **Insured's** Date of Birth _____

Insured's Social Security Number_____

*****If patient is full time student over the age of 19, please provide**:

College name:_____Expected date of graduation:_____

Do you have secondary dental insurance: Yes ____ No____ (If yes, please see business office)
Insured:_____ **Employer**_____
Insurance Company_____

Authorization and Release: I certify that I have read and do understand the foregoing information and to the best of my knowledge have answered all questions completely and accurately. I authorize DeMartin Dental Associates, PC to release/exchange any information necessary involving treatment or examination rendered to me or my child to any health practitioners, insurance company(s), and/or claim administrator(s). If applicable I authorize and request my insurance company to pay directly to DeMartin Dental Associates, PC benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment in full of all services rendered on my behalf or for my dependent(s).

SIGNATURE:_____ **** AND ****
Patient/parent or legal guardian

PRINT YOUR NAME_____**Date:**_____
Patient/parent or legal guardian