

DeMartin Dental Associates

(REV.05/19)

DATE _____

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

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, etc.) YES NO

Latex gloves commonly used in dental procedures? YES NO

Are you taking any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Aspirin or aspirin like drugs | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Heart Medications |
| <input type="checkbox"/> Anticoagulant (Blood thinners) | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Nitroglycerine |
| <input type="checkbox"/> High blood pressure Medications | <input type="checkbox"/> Hormone pills | <input type="checkbox"/> Antibiotic/Sulfa drugs |
| <input type="checkbox"/> Steroids (cortisone, prednisone) | <input type="checkbox"/> Anticonvulsive drugs | <input type="checkbox"/> Synthroid/Thyroid drugs |
| <input type="checkbox"/> Cancer Therapy Medications | <input type="checkbox"/> Insulin, Orinase or similar blood sugar drugs | |
| <input type="checkbox"/> Sedatives or sleeping pills | <input type="checkbox"/> Other Medications _____ | |
| <input type="checkbox"/> Osteoporosis medications | <input type="checkbox"/> Non-prescription medications _____ | |

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

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

*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: _____ **Date:** _____ **Dentist Initials** _____
Patient/parent or legal guardian