The Dentists of Naugatuck Valley

Name_____ Birth date_____

Address_____ City_____ Zip code_____

Home #_____ Cell #_____ Which do you prefer? Home Cell

Pharmacy:_____ For any prescriptions needed

Place of employment_____ Work #_____

Can we call you at work if we can't reach you on your cell? Yes NO

Do you have DENTAL insurance? Circle: Yes No **Do NOT list Medical Insurance!** *If YES, please hand card to the receptionist.*

Name of DENTAL insurance company_____

Is this a new policy? Yes *No* This office is not responsible for any third party benefits. The responsibility is the patients'.

Have there been any changes to your health history since your last dental visit? Yes No

If yes, please explain: _____

_____

Are you under a doctor's care now? Y N if yes_____

Please list all **prescribed** medications taken daily: _____

_____

Are you taking any over the counter medication at this time? Yes No

If yes, Please list: _____

Any known allergies/INCLUDING MEDICATION_____

_____

Any changes to your DENTAL history since last visit?_____

DO YOU TAKE A LOW DOSE ASPIRIN? Y N

ARE YOU TAKING A BLOOD THINNER? (NOT aspirin) Y N

Prescription name: _____

Women Only: Pregnant? Y N Nursing? Y N Taking Oral Contraceptives? Y N

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU:

High Blood Pressure	Swollen Ankles	Mitral Valve Prolapse	Easily Winded	Diabetes
Fainting/Seizures	Use of controlled substance	Tuberculosis	Stomach trouble	Anxiety
Thyroid Problems	Radiation Therapy	Low Blood Pressure	Emphysema	Depression
Glaucoma	Epilepsy/Convulsions	Tobacco use	Recent weight loss	Asthma
High Cholesterol	Liver Disease	Dental anxiety	Anemia	Ulcers
Angina	Rheumatic fever	Kidney Disease	Hepatitis/Jaundice	
Respiratory Problems	H I V or A I D S	any S T D or S T I	Allergies/hay fever	
Stroke	Heart Disease	Chest Pains	Heart Attack	Heart Murmur	Cardiac Pacemaker

Any Heart Problems: Specify_____

Have you had a joint replacement surgery? Y N When:_____ What:_____

Have you ever had any form of cancer? Y N When:_____
What:_____

Do you need to pre-med for dental work? Y N Did you today? Y N

What do you take as your pre-medication?_____

*Name of your physician*_____ date last seen_____

Do you have a cardiologist? Y N Name_____ Date last seen _____

Why did you see a cardiologist?_____

_____

*All fees are **the patient's** responsibility. Third party benefits (insurance payments) will be applied to the patient's account. The balance will be due payable within thirty days. Payment plans must be made if the balance will be carried for more than thirty days. Please be aware that third party benefits are beyond our control and may differ from what were expected. As we are out of network providers, all patients are responsible for knowing what their insurance covers. *Patients are responsible for any procedure fees that are not covered by their insurance company.* **If claims are not paid within 60 days, the balance is the patient's responsibility and insurance will reimburse the patient.** **All balances carried for more than 90 days will be charged an interest fee.** *All cancellations need a full 24 hours notice to avoid a charge.*

Signature_____ Date_____

Financial Policy for The Dentists of Naugatuck Valley

Thank you for trusting us to see to your dental health needs. We strive to provide you with the best care in the most cost effective manner. To keep you informed of our office and financial policies, we ask that you read and sign this document.

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*According to the insurance commissioner of the state of CT, the patient is responsible for services not covered by the insurance company. **Patients are responsible for knowing what services are covered under their plan.** This includes frequencies and limitations. *Our office must bill the visit according to the service codes provided by the ADA. We cannot change them to fit within your insurance plan.*

*It is the patient's responsibility to verify that we have the correct insurance carrier and mailing address on file. Failure to notify us of changes will result in the balance being the patient's responsibility.

*Patients will receive a monthly statement. After the initial statement, you will not receive an itemized list of services and payments. It will state only the balance due.

*Unless specific arrangements have been made **in advance**, if your account carries for more than ninety days, your account will be charged a finance fee. If there is no activity on your account for more than ninety days, your account may be turned over to an outside collection agency. You will be responsible for any and all collections fees. Patient care can be terminated if the account remains to be delinquent

.*Please know that payment plans can be made for any account. We will work with you on the best possible arrangement.

***For our patients with no dental insurance**, Payment is expected on the day of your visit. If you pay on the same day with **cash or check**, you will receive discount.

Due to circumstances beyond our control, **DISCOUNTS CAN NO LONGER BE GIVEN TO ANY ACCOUNT BEING PAID BY CREDIT, DEBIT,OR HSA CARD.**

Cancellation Policy

Our office requires 24 full hours notice for any and all cancellations. Failure to do so will result in a broken appointment fee. This fee must be paid before we can reschedule your appointment.

I have read and agree. Signature _____

Please print name:_____ Date_____