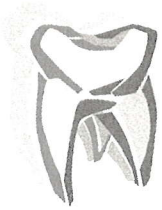

Oceanside Family Dental, PC
421 Lafayette Road
Hampton, NH 03842
Phone: 603-926-1551 **Fax:** 603-926-1563
www.oceansidedental.net

WELCOME

Appointment: _____/_____/_____ at _____:_____

Received in office: _____/_____/_____

Patient Information

Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

First Name:	Middle:	Last Name:		Date:
Physical Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
☐ Home Phone:	☐ Work Phone:		☐ Cell Phone:	
Please check preferred daytime contact phone / email				
☐ Email Address:	Birth date:	Age:	SS#:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
You or your parent's employer:		Occupation:		
Business Address:	City:		State:	Zip:
Person to contact in case of emergency:		Relationship:	Phone:	
Name of closest relative <u>not</u> living with you:		Relationship:	Phone:	
Whom may we thank for referring you to us?				

Responsible Party

Name of person responsible for this account:			Phone:
Relationship to patient:	Employer:		Phone:
Business Address:	City:	State:	Zip:

Dental Benefits

Name of insured:		Relationship to patient:	
Birth date:	SS#:	Date of employment:	
Name of employer:		Phone:	
Business Address:	City:	State:	Zip:
Insurance Co.:	Group#:	Employer#:	
Business Address:	City:	State:	Zip:
Deductible:	How much of annual benefit used?	Maximum annual benefit:	

Secondary Insurance

Name of insured:		Relationship to patient:	
Birth date:	SS#:	Date of employment:	
Name of employer:		Phone:	
Business Address:	City:	State:	Zip:
Insurance Co.:	Group#:	Employer#:	
Deductible:	How much of annual benefit used?	Maximum annual benefit:	

Dental History

Why have you come to the dentist today?_____

Are your teeth sensitive to heat, cold or anything else? _____

Are you currently in pain? ❑Yes ❑No

Do you have mobility in your teeth? ❑Yes ❑No

Do you require antibiotics before dental treatment? ❑Yes ❑No

Do you still have wisdom teeth? ❑Yes ❑No

Your current dental health? ❑Good ❑Fair ❑Poor

Previous Dentist _____ Last visit _____

Do you floss daily? ❑Yes ❑No Brush daily? ❑Yes ❑No

Would you like fresher breath? ❑Yes ❑No

Type of bristles in your toothbrush? ❑Hard ❑Med ❑Soft

Would you like whiter teeth? ❑Yes ❑No

Do your gums ever bleed? ❑Yes ❑No Ever itch? ❑Yes ❑No

Are you happy with the way your smile looks? ❑Yes ❑No

Have you ever had periodontal disease? ❑Yes ❑No

If not, what would you change?_____

Medical History

Do you have a personal physician? ❑Yes ❑No	Are you currently under the care of a physician? ❑Yes ❑No
Physician's name:	Please explain:_____
Address: City: State: Zip:	Have you ever taken Phen-Fen, Redux or Pandimin? ❑Yes ❑No
Phone: Date of last visit:	***For women***: Are you taking birth control? ❑Yes ❑No
Your current physical health? ❑Good ❑Fair ❑Poor	Are you pregnant? ❑Unsure ❑Yes ❑No
Do you smoke or use tobacco in any form? ❑Yes ❑No	Week#_____ Are you nursing? ❑Yes ❑No

Do you or have you experienced the following? (check all that apply)

❑ Abnormal bleeding	❑ Colitis	❑ Hay Fever	❑ Liver disease	❑ Shingles
❑ Alcohol abuse	❑ Congenital heart	❑ Headaches	❑ Low blood pressure	❑ Sickle Cell Disease
❑ Anemia	❑ Diabetes	❑ Heart attack	❑ Lupus	❑ Sinus problems
❑ Arthritis	❑ Difficulty breathing	❑ Heart murmur	❑ Mitral valve prolapse	❑ Steroid Therapy
❑ Artificial bones/joints	❑ Drug abuse	❑ Heart surgery	❑ Pacemaker	❑ Stroke
❑ Artificial valves	❑ Emphysema	❑ Hemophilia	❑ Persistent cough	❑ Thyroid problems
❑ Asthma	❑ Epilepsy	❑ Hepatitis	❑ Psychiatric problems	❑ Tonsillitis
❑ Blood transfusion	❑ Ever hospitalized	❑ Herpes	❑ Radiation treatment	❑ Tuberculosis (TB)
❑ Cancer	❑ Fainting spells	❑ High blood pressure	❑ Rheumatic Fever	❑ Ulcers
❑ Chemotherapy	❑ Fever blisters	❑ HIV+/AIDS	❑ Scarlet Fever	❑ Venereal Disease
❑ Chicken Pox	❑ Glaucoma	❑ Kidney problems	❑ Seizures	

Please list any serious medical conditions that you have experienced:

Do you take any prescription/over the counter drugs? ❑Yes ❑No Please list:

Are you allergic to any of the following? (check all that apply)

❑ Aspirin	❑ Codeine	❑ Erythromycin	❑ Latex	❑ Sedatives	❑ Tetracycline
❑ Barbiturates	❑ Dental anesthetics	❑ Jewelry/metals	❑ Penicillin	❑ Sulfa drugs	❑ Other

Please list anything additional that causes allergic reactions:

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Print full name:_____ **Signature:**_____ **Date:**_____

Reviewed by: _____ **Date:**_____

Oceanside Family Dental, PC

FINANCIAL POLICY

In an effort to provide quality dental care to our patients and to avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not covered by these benefits is the responsibility of the patient and due at the time service is rendered. This amount will include deductibles and co-payments.

Your dental benefit is a contract between you and your insurance company. We will make every effort to assist you with any benefit questions, however, we suggest that you be aware of what benefits you have available. Our office is not responsible for your dental benefits or its limitations.

Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide the other parent for reimbursement.

There is a $25.00 charge for returned checks. There is a 1.5% finance charge (18% annually) which will be added to any balance over 60 days. In the event of default you are responsible for interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

For your convenience, we accept: **Cash, Check, Visa, MasterCard, Discover, American Express** and **Care Credit** (A dental credit card. Ask our staff for an application and details.)

Broken Appointment Policy

Our office requires 24 hour notice for cancellation or rescheduling of an appointment. If 24 hours is not given, a broken appointment fee will be charged based on the length of the appointment.

Notice of Privacy Practices

A copy of this offices notice of privacy practices will be provided at a cost.

Dental Material Fact Sheet

A copy of this offices Dental Materials Fact Sheet will be provided.

By signing below, I understand and accept the terms of the office Financial Policy and Broken Appointment Policy.

Signature: _____ **Date:** _____
(Patient, Parent or Legal Guardian)

Print Full Name: _____

Oceanside Family Dental, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of your treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Susan R. Wheeler, Privacy Officer

Telephone: 603-926-1551 Fax: 603-926-1563

E-mail: _____

Address: 421 Lafayette Road Hampton NH 03842

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.