ANDROSCOGGIN
DENTAL GROUP

PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name:_____Middle Initial:___

Preferred Name: _____

Address:_____City:_____State/Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

I would like to receive email / text for confirming my appointments and specials the practice runs

E-mail:_____

Birth date:_____ Social Security #:_____ Drivers Lic#: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Life Partner ○ Widowed

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____

Birth date: _____ Social Security #:_____

Preferred Pharmacy:_____

How did you hear about Androscoggin Dental Group?_____

Previous Dental Office Name: _____

Date of Last Visit: _____

DENTAL **Insurance Information:** _____ **(check if) NONE**

Name of Insured:_____

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Carrier ID:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

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Appointment Policies

Androscoggin Dental Group is dedicated to providing our patients with the highest quality of care. We know that efficient scheduling is a crucial part of your dental experience and we appreciate your respect for our schedule. Appointment times are specifically arranged in order to provide you with effective, thorough and comfortable dental care. Out of respect and consideration to our staff and other patients we have implemented the following appointment policies:

Late Arrival:

When a time is reserved for our patients, we require ALL of that time to be able to provide you with the highest level of quality care. When you are late, it decreases our ability to accomplish this. **Patients arriving 10 minutes or later to their appointments will be rescheduled** in order to meet the needs of those who are on time for their confirmed visit.

Unconfirmed Appointments:

As a courtesy to our patients, we call up to 2 days prior to your appointment to remind you of your appointment and answer any additional questions you may have. **If we are unable to confirm your appointment by 12 pm one business day before your scheduled appointment, it is considered an unconfirmed appointment and will be taken off our schedule.** Please insure you have provided us with phone number(s) where we can best reach you or leave you a message during daytime hours.

X _____ **Date** _____

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Medical History

If you have or have had any of the following please circle and list dates?

Acid Reflux
AIDS/HIV Positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Joints
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pain
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema / COPD
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growth
Ulcer
Venereal Disease
Yellow Jaundice

Medical History

Have you ever had any other serious Illness not listed? ☐ Yes ☐ No
If yes: _____

Name of your primary care physician and or Specialist's Doctors? ☐ Yes ☐ No
If yes: _____

Have you been hospitalized or had a major operations? ☐ Yes ☐ No
If yes: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If yes: _____

Are you taking any Medications, Injections, Over the Counter Meds ☐ Yes ☐ No
Or Supplements?
If yes: _____

Do You Take or have you taken Phen-Fen or Redux ☐ Yes ☐ No
If yes: _____

Do you Use Controlled Substances? ☐ Yes ☐ No

If yes: _____

Have you ever Taken Fosamax Boniva, Actonel or any
Other Medications containing Bisphosphonates? ☐ Yes ☐ No
If yes:_____

Are You on a Special Diet? ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No

Women: Are You?

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetic

Other Allergies? ☐ Yes ☐ No If Yes _____

Patient Signature: _____ Date: _____

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GENERAL CONSENT FOR TREATMENT

I hereby authorize and request the Dentist to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the Dentist. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the Dentist. The Dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind, and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the Dentist and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have discussed payment options and agreed upon a plan for payment.

ACKNOWLEDGEMENT: By signing this document, I acknowledge that I have read this informed consent or it has been read to me, and that I have had an opportunity to ask any questions and that all questions have been answered. I fully understand the entire document and possible risks, complications and benefits that can result from the treatment, and that I give permission for the treatment to be performed on me. I also state that I read and write in English.

Patients Signature: _____ Date:_____

ANDROSCOGGIN
DENTAL GROUP

Welcome to our office

The doctors and staff welcome you to our office and sincerely appreciate the trust you have shown by selecting us to serve your dental needs. Our goal is to provide the very best possible dental care so you may achieve and maintain optimal dental health throughout your lifetime. Our highly trained staff operates as a team and uses the most modern techniques and equipment. Today we can teach you how to prevent tooth decay and gum disease, as well as show you the way to a beautiful smile! Our mission is to provide you with affordable dental excellence. The more you know about our policies and practice, the better we can serve you.

Office Hours **Monday – Friday 8am-5pm**

We are currently closed on most Fridays, Saturdays, Sundays New Year's Eve/New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas/Christmas Eve

Appointments: Patients are seen by appointment **only**. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. As a courtesy to you, the staff attempts to confirm appointments 2 business days before; however, if we cannot contact you, it is your responsibility to keep the appointment. If you are unable to keep an appointment, we ask that you give us at least **24 hour business day notice** so that we are able to give your appointment time to another patient**.** This is the only way we can operate without "double booking" in anticipation of appointment failures which can be a real inconvenience to you. Please be aware that appointment time is very important to our patients, therefore, if you fail or late cancel more than 2 appointments, **Androscoggin Dental Group** reserves the right to extend same day appointments to you in the future to avoid this issue. We may also consider you for outright dismissal from the practice depending on the account history.

If you are ten minutes (or more) late for your appointment, you will need to be rescheduled.

Fees, Payments & Insurance: Payment in Cash or Check and for your convenience, we also accept all major credit cards. Additionally, we will be happy to file a dental claim on your behalf to your insurance company for their portion of the visit. Androscoggin Dental Group requests that all co-payments and co-insurance payments be paid at time of service. For your convenience, we do now offer a payment option called Care Credit and Proceed which you may be eligible for, we can tell you how to apply.

Thank you for choosing our office to help you reach your oral health potential. We look forward to working with you!

Patient Signature: _____ Date: _____

ANDROSCOGGIN
DENTAL GROUP

Insurance . . . (What's it all about?)

Dear Patient:

We realize that navigating through the stormy waters of dental insurance coverage can be tough, therefore, we have prepared this letter to help you better understand the complexities that lie ahead. Believe it or not, there is nothing to fear!

Throughout the history of mankind, myth and legend have been slowly replaced by science and fact. All we really strive for as human beings is the truth in our existence. The truth is, **DENTAL INSURANCE IS NOT DESIGNED TO PAY FOR ALL DENTAL CARE.** In reality, an insurance policy is a contract between you and your insurance company. Most insurance contracts have coverage limits and/or various degrees of co-payment for which you, the policyholder, are responsible. These are their rules, not ours.

All levels of coverage, allowed fees (referred to as 'reasonable and customary'), and thus claim payment by insurance companies are governed by the premiums paid by either you, or in some cases, by your employer. Please do not complain to us about the amounts, allowances, limits or other peculiarities of your coverage, we have absolutely no control over them. All such questions or complaints need to be directed to the benefit provider or your human resource department at work.

Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality of dental care. Please be aware that our fees are in no way derived from insurance company allowances, as we are NOT involved in any way with your carrier. Therefore, the treatment recommended by our office is NEVER based upon what your insurance company will or will not pay. Your treatment plan is determined solely upon what is in the best interest of your health. Remember, the dental insurance contract is between you and your insurance company while the treatment plan is made between you and the office. Same for certain Delta Dental patients, there is NO contract between this office and your insurance company. Therefore regardless of how financing dental treatment is achieved, the ultimate responsibility for payment lies with you, the patient. As a convenience to you, we offer the service of submitting your insurance claims, however, if insurance does not remit the expected payment, you are responsible for the balance due.

We hope that this information clears a bit of the insurance fog. Please take the time to review your insurance contract thoroughly so we may best serve you. If you have any questions, please do not hesitate to call our office.

Patient Signature: _____ Date: _____

ANDROSCOGGIN
DENTAL GROUP

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. PERMISSION TO USE AND DISCLOSE MY HEALTH INFORMATION. BY SIGNING THIS FORM, I GIVE ANDROSCOGGIN DENTAL GROUP PERMISSION TO USE AND/OR DISCLOSE MY HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

2. RIGHT TO REFUSE. I HAVE THE RIGHT NOT TO SIGN THIS CONSENT. IF IS REFUSE TO SIGN THIS CONSENT, ANDROSCOGGIN DENTAL GROUP WILL NOT PROVIDE ME WITH TREATMENT UNTIL I CONSENT. HOWEVER, TREATMENT REQUIRED BY LAW, SUCH AS EMERGENCY CARE, , CAN BE PROVIDED WHETHER OR NOT I SIGN THIS CONSENT.

3. CHANGES TO THE PRIVACY NOTICE. ANDROSCOGGIN DENTAL GROUP MAY CHANGE THE PRIVACY PRACTICES AS NEEDED. I MAY OBTAIN A CURRENT COPY OF THE ANDROSCOGGIN DENTAL GROUP PRIVACY PRACTICES BY CONTACTING ANDROSCOGGIN DENTAL GROUP.

   RIGHT TO REQUEST RESTRICTIONS ON USE/DISCLOSURE. I HAVE A RIGHT TO REQUEST THAT ANDROSCOGGIN DENTAL GROUP RESTRICT HOW THEY USE AND/OR DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF PROVIDING TREATMENT, OBTAINING PAYMENT FOR SERVICES, AND/OR CONDUCTING HEALTH CARE OPERATIONS. ANDROSCOGGIN DENTAL GROUP IS NOT REQUIRED TO AGREE TO ANY RESTRICTION I REQUEST. IF ANDROSCOGGIN DENTAL GROUP DOES DECIDE TO AGREE TO MY REQUEST, IT MUST RESTRICT THEIR USE AND OR/DISCLOSURE OF MY HEALTH INFORMATION THE WAY I ASKED. BECAUSE OF THE NUMBER, COMPLEXITY, AND NATURE OF SERVICES WE DELIVER, ANDROSCOGGIN DENTAL GROUP WILL RARELY AGREE TO REQUESTS TO RESTRICT USES AND DISCLOSURES OF MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. IF I WISH TO REQUEST THE RESTRICTIONS, I CAN CONTACT ANDROSCOGGIN DENTAL GROUP. ANDROSCOGGIN DENTAL GROUP WILL NOTIFY ME OF DECISION TO ACCEPT OR DECLINE MY RESTRICTIONS.

4. RIGHT TO WITHDRAW CONSENT. I HAVE THE RIGHT TO WITHDRAW THIS CONSENT AT ANY TIME. I MUST DO THIS IN WRITING. IF I WANT TO WITHDRAW THIS CONSENT, I CAN CONTACT ANDROSCOGGIN DENTAL GROUP 488 SABATTUS STREET, LEWISTON ME 04240. NOTE THAT MY WITHDRAWAL OF THIS CONSENT WILL NOT BE EFFECTIVE FOR USES AND OR DISCLOSURES THAT HAVE ALREADY BEEN MADE BASED ON MY PRIOR CONSENT. IF I WITHDRAW THIS CONSENT THEN ANDROSCOGGIN DENTAL GROUP, BY LAW, IS UNABLE TO PROVIDE ME WITH FURTHER TREATMENT OR FOLLOW UP, OTHER THAN REQUIRED EMERGENCY SERVICES.

5. EFFECTIVE PERIOD. THIS CONSENT IS ACTIVE UNLESS AND UNTIL I WITHDRAW IT IN WRITING.

6. REFERENCES TO "I" OR "ME". REFERENCES TO "I" OR "ME" IN THIS CONSENT INCLUDE THE INDIVIDUAL FOR WHOM THE SIGNING PARTY IS AUTHORIZED TO SIGN. IF I AM SIGNING THIS CONSENT ON BEHALF OF ANOTHER PERSON, IT IS BECAUSE I AM THE LEGAL GUARDIAN, PARENT, OR AGENT UNDER AN ACTIVE POWER OF ATTORNEY FOR HEALTH CARE, AND AM LEGALLY AUTHORIZED TO SIGN THIS CONSENT ON BEHALF OF THE INDIVIDUAL.

   I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED A COPY OF ANDROSCOGGIN DENTAL GROUPS NOTICE OF PRIVACY PRIVACY PRACTICES, WHICH HAS AN EFFECTIVE DATE OF 9/23/2013 AND WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED, I UNDERSTAND THAT YOU HAVE THE RIGHT TO CHANGE THE NOTICE OF PRIVACY PRACTICES AT ANY TIME, THAT I WILL BE PROVIDED A COPY OF ANY UPDATED VERSION, AND THAT I MAY CONTACT YOU AT ANY TIME TO REQUEST A CURRENT NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE:_____DATE_____

FOR OFFICE USE ONLY:

_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

__COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

__AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

__OTHER (PLEASE SPECIFY)_____