Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone (____) _____ Alt. Phone (____) _____

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

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Please Complete Both Sides

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking:

_____

_____

_____

ALLERGIES

_____

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

365 Willard Avenue
Newington, CT 06111
(o)860-666-7910 (f)860-666-8441
Email: Newingtonfd@gmail.com
Website: www.newingtonfamilydentistry.com

Dr. Theodore J. Adamidis, DMD
Dr. Bing Dai, D.M.D.
Dr. Aurora Dibner, DMD, MDS, FACP

Consent for Services and Financial Policy

*Teeth Cleaning Disclaimer: Regular dental cleanings are only performed on patients with good oral health and who have had a dental cleaning within the last 12-18 months. Regular dental cleanings consist of ONLY cleaning plaque or calculus ABOVE the gum line according to the American Dental Association. If a patient has plaque or calculus to be cleaned below the gum line, then a regular dental cleaning CANNOT be performed. A full set of x-rays along with an evaluation by the Dentist and/or Dental Hygienist will determine if a patient is eligible for a standard dental cleaning or if the patient requires a more in-depth dental service.

*X-ray Disclaimer: All new patients (children's x-rays differ by age) are required to have a FULL set of dental x-rays taken at his/her initial appointment. You are encouraged to have your previous dentist email our office a full mouth series of x-rays (FMX) that have been taken within the last 3 years. Newington Family Dentistry must receive your previous FMX PRIOR to your scheduled new patient appointment. If any emailed copy is not received by the SCHEDULED start of your dental appointment, our policy is to take a new set of full mouth x-rays whether they are covered or not by your insurance company. If a patient does not agree to have x-rays taken, unfortunately we cannot continue with the appointment

CANCELLATIONS AND LATE POLICY: If you are unable to make it to your scheduled appointment, please be sure to call the office at (860) 666-7910 (2) days in advance to avoid a cancellation charge. Charges are $50.00 per hour for all missed appointments. Newington Family Dentistry has a 15-minute late policy. After 15 minutes we MAY need to cancel your appointment and reschedule and a fee may incur. For those patients with unpredictable schedules, we ask that you please make same day appointments only. (3) of more missed or short notice cancellations may result in the patient pre-paying for all dental appointments.

PAYMENT OPTIONS: We accept Visa, MasterCard, Discover, American Express, CareCredit, Cash, and Check.

CO-PAYS: All co-pays are due in FULL at the time of service unless other financial arrangements have been previously agreed upon. Dental insurance claims are processed as a courtesy; each patient is financially responsible for his/her account in the event insurance does not make a payment to Newington Family Dentistry within 30 business days. We only send billing out if the patient owes more than collected at their date of service.

COLLECTIONS PROCEEDINGS: In the event that any patient and or parent or guardian of a patient is sent to collections due to non-payment, Newington Family Dentistry will not treat or complete any dental treatment until account is paid in full and a zero balance is reached. This includes all services such as orthodontic, implant, denture, crown, or dental appliances.

INSURANCE & PATIENT ACCOUNTS: Accounts are the patient's responsibility. If for any reason your insurance company does not pay within 30 business days, it becomes the patient's responsibility to call the insurance company for details and/or explanations. If no payment is remitted to Newington Family Dentistry within 30 business days, patients are responsible for any and all balances remaining and will be obligated to pay Newington Family Dentistry within 21 days unless a prior payment plan has been made. As a courtesy, we contact your insurance company for a breakdown of your benefits; the information given over the phone to us by your dental insurance company is NOT a guarantee and only a verbal estimate. It is each patient's duty to read, review and understand his/her dental insurance plan, frequencies, maximums, deductibles and limitations.

UNDERSTANDING BASIC DENTAL COVERAGE AND BENEFITS* Our goal is to provide the finest care and treatment to all our patients at a reasonable cost in a safe, clean, comfortable, and friendly environment. All charges you incur for any treatment that is provided to you are your responsibility regardless of your insurance coverage. As a dental professional we will always recommend treatment based upon your dental needs and not based on insurance coverage. Some dental plans may not allow benefits for all available options even when your dentist determines that a specific treatment is in your best interest. The least expensive alternative is not always the best option. Please remember that your dental plan may not cover certain procedures or treatments regardless of their value to you. Although we are willing to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance breakdowns is a courtesy we extend in an effort to save you time and facilitate payment to our practice from your insurance company. By having our practice process the insurance forms, it is important that the patient and/or responsible party understand that this does not eliminate your financial obligation. Insurance payments are normally received within 30 to 60 business days from the time of billing. If the insurance company has not made payment to our practice within 60 days, we may ask the patient and/or responsible party to pay the entire balance at that time and it will be their responsibility for seeking reimbursement from your insurance company. It is the responsibility of the patient and/or responsible party for resolving any type of dispute over payments made or not made by your insurance company to our practice.

ELIGIBILITY: The insurance company does not notify this office regarding eligibility. It is the patient's responsibility to notify this office of any new dental plans, termination, or for any changes to your dental plan.

LIMITATIONS AND EXCLUSIONS: There are certain limitations and exclusions which may apply to your dental plan. For example, some dental plans may include an alternative benefit or sometimes called a downgrade clause that may be applied to some services. Please be aware that a downgrade clause means that the insurance will pay for the "least expensive treatment" and the patient is responsible for the difference in cost. For example, some dental plans will only pay for an amalgam filling (silver filling) toward the office charge of a multi surface posterior composite filling (white filling on the back teeth) and will result in a larger payment for the patient.

INSURANCE MAXIMUM: The maximum dollar amount the insurance company will pay toward the cost of ALL dental care incurred by an individual in a specific period, usually in a calendar year. Please be aware that any amount that goes over the maximum is the patient's responsibility. We must be notified by the patient if any treatment was performed at another dental office/facility within the year for insurance maximums and used to date benefits to be accurate. If this this information is not disclosed the patient is responsible for any/all balances accrued.

INSURANCE PARTICIPATION: We accept all PPO dental insurance plans and are consider in-network with a few select plans. These in-networks plans can/may change yearly. Please make sure to verify in-network status prior to your first appointment of a new calendar year. We DO NOT accept HUSKY or HMO/DMO dental plans.

EXPLANATION OF BENEFITS (EOB): Our estimate of your patient payment at the time of service is usually fairly accurate. In about 30 days you and the dentist will receive an EOB from the insurance usually indicating the services that are covered, any insurance payment submitted to the provider, how much was paid by your dental plan, maximum used, and how much is your patient responsibility. In some cases, a difference in payment will occur as all financial are ONLY AN ESTIMATE provided by YOUR DENTAL INSURANCE COMPANY to us. The estimate we receive from your dental insurance company is NEVER a guarantee.

This signed document indicates that the (patient/guardian) read, received, reviewed, and understood any/all information listed above and is agreeing to all terms and policies for Newington Family Dentistry including the collection or charges of any/all fees.

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature X: _____

HIPAA Acknowledgment

I have been given the option to read and/or keep a copy of the notice of privacy practice form at Newington Family Dentistry. **X_____ (Initials)**

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Please list the first and last names of any person(s) we may discuss your appointment, treatment, and or financial obligations with:

1.) _____ **2.)** _____

Patient Name _____ Patient Signature X:_____ Date: _____

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Newington Family Dentistry, to take photographs and/or intra-oral photographs of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Marketing material, including websites, printed materials, and patient education

I further understand that if the photographs are used, my name and ALL other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____Check here if you **do not** want any of your photos used or shared for any of the above purposes

Signature (Patient) X_____ Date _____

NEWINGTON FAMILY DENTISTRY 860.666.7910

Smile Questionnaire

What is your immediate concern about your dental health? _____

If you could change anything about your smile, what would you change? _____

Please check off all that apply

- ☐ **Had complications from past dental treatment**
- ☐ **I would like my teeth straighter**
- ☐ **Had/Have braces or orthodontic treatment**
- ☐ **Experiences dry mouth**
- ☐ **Sensitive to hot, cold, biting, sweets**
- ☐ **Avoid brushing any part of your mouth**
- ☐ **Food gets trapped between any teeth**
- ☐ **Interested in having a brighter, whiter smile**
- ☐ **Experienced popping and/or clicking of your jaw joint**
- ☐ **Difficulty chewing**
- ☐ **Clenching or grinding of teeth**
- ☐ **Currently or previously wore a bite appliance**
- ☐ **Gums bleed when brushing or flossing**
- ☐ **Diagnosed and/or treated for gum disease**
- ☐ **I have missing teeth that I would like to replace**
- ☐ **Noticed an unpleasant taste or odor in your mouth**
- ☐ **Experienced gum recession**
- ☐ **Teeth become loose on their own (without injury)**
- ☐ **Would you like your teeth straighter**
- ☐ **Snores or a lack of restful sleep**

Patient Name:_____ **Date:** _____