Pittsfield Family Dental Center
Dr. Deborah K. Varney, D.M.D., PLLC

PATIENT INFORMATION

Name: _____ Sex: M F
Last First MI

Address: _____
Street City State Zip

Phone: Home_____ Business_____ Cell Phone_____

e-mail_____ Birth Date: _____/_____/_____ Soc .Sec. # _____-_____-_____

PERSON RESPONSIBLE FOR ACCOUNT OR HOLDER OF INSURANCE

Patient Other Relationship to Patient: _____

If other than patient, Name: _____
Last First MI

If different address: _____
Street City State Zip

Phone:_____ Birth Date: _____/_____/_____ Soc .Sec. # (_____-_____-_____)

EMPLOYER INFORMATION

Employer:_____

Address: _____
Street City State Zip

PRIMARY DENTAL INSURANCE

Company Name: _____

Group #_____ Policy #_____

SECONDARY DENTAL INSURANCE

Company Name: _____

Group #_____ Policy #_____

AUTHORIZATIONS

- I hereby authorize and request the performance of dental services for myself or my dependent by Dr. Deborah K Varney and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Deborah K Varney and staff for diagnostic purposes or dental treatment.
- I acknowledge that I have had the opportunity to read the financial policy of Pittsfield Family Dental Center.
- I understand that I am responsible for all cost of treatment rendered, regardless of insurance coverage.
- I authorize payment directly to Pittsfield Family Dental Center, of any dental insurance benefits payable to me. My signature from this form may be used in place of my signature on each insurance form.

_____

SIGNATURE OF RESPONSIBLE PARTY Date

Pittsfield Family Dental Center
MEDICAL HISTORY

Patient Name_____ Patient Date of Birth_____

Medical Physician's Name_____ Date of Last Physical_____

Medical Physician's Address & Phone #_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions:

Are you under a physician's care now? ___No ___Yes Are your immunizations up to date? ___No ___Yes

Have you ever been hospitalized or had a major operation? ___No ___Yes

Women: Are you pregnant or nursing? ___No ___Yes

Have you ever had a serious head or neck injury? ___No ___Yes

Are you taking any medications, pills, or drugs? ___No ___Yes If yes, please list_____

_____

Are you ***ALLERGIC*** to any of the following? ___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal

___Latex ___Local Anesthetics ___Other, please list_____ ___No Known Allergies

Do you use **tobacco** products? ___No ___Yes If yes, how much? _____

Please check if you have any of the following?

___AIDS/HIV Positive	___ Chest Pains	___Glaucoma	___Low Blood Pressure	___Stroke
___Alzheimer's Disease	___Cold Sores/Fever Blisters	___Heart Attack/Failure	___Lung Disease	___Swelling of limbs
___Anaphylaxis	___Congenital Heart Disorder	___Heart Murmur	___Mitral Valve Prolapse	___Thyroid Disease
___Anemia	___Cortisone Medicine	___Heart Pace Maker	___Pain in Jaw Joints	___Tuberculosis
___Angina	___Diabetes	___Heart Trouble/Disease	___Parathyroid Disease	___Tumors/Growths
___Arthritis/Gout	___Drug Addiction	___Hepatitis A, B, or C	___Psychiatric Disease	___Ulcers
___Artificial Heart Valve	___Epilepsy/Seizures	___High Blood Pressure	___Radiation Treatment	___Venereal Disease
___Artificial Joint	___Excessive bleeding	___Hives or Rash	___Recent Weight Loss	___Yellow Jaundice
___Asthma	___Excessive Thirst	___Hypoglycemia	___Rheumatic Fever	___Other:_____
___Blood Disease	___Fainting Spells/ Dizziness	___Irregular Heartbeat	___Scarlet Fever	
___ Cancers	___Frequent Diarrhea	___Kidney Problems	___Sinus Troubles	
___ Chemotherapy	___Frequent Headaches	___Liver Disease	___Stomach/Intestinal Disease	

Have you ever had any serious illness not listed above that you think we should know about? ___No ___Yes

If yes, please list _____

COMMENTS: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

FOR OFFICIAL USE ONLY:

REVIEWED BY_____ DATE_____

BLOOD PRESSURE_____/_____PULSE_____ MEDICAL ALERTS_____

Pittsfield Family Dental Center

50 Manchester Street
Pittsfield, NH 03263

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I am able to receive your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to changes its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Pittsfield Family Dental Center

Deborah K Varney D.M.D. PLLC

Financial Policy

Welcome to our dental practice! So that you are comfortable understanding our payment policy ahead of time, please review the following items before your appointment. We have found that clear communication about finances will help avoid problems later on.

Payment for dental services is expected at the time they are received. For the patient who has dental insurance, payment means deductibles as well as the anticipated or estimated portion that is not covered by insurance. You and your employer have a contract with your dental insurance company and we submit insurance on your behalf as a courtesy. It is your responsibility to provide accurate information for quick claim processing. In the rare event a claim is denied, our staff is highly trained in any appeals process, however after 90 days, the balance is your responsibility to pay in full. We will continue every effort to get your claim paid, until all avenues are exhausted.

To aid you with meeting your financial obligations, we accept cash, personal check and all major credit cards. We also offer Care Credit should you need to extend payments. Please inquire with our highly trained staff about these payment options.

If a check is returned to us it will incur a fee equal to the returned check fee or $30.00 whichever is greater.

Cancellations and Broken Appointments

Because every effort is made to keep on schedule, we respectfully ask patients to be prompt to their reserved time and keep their appointments scheduled. If you need to change an appointment, we ask (2) business days notice to avoid a charge for the lost time.

If you have any questions concerning these policies, please speak with our staff.

Pittsfield Family Dental Center
Deborah K. Varney D.M.D., PLLC
50 Manchester Street
Pittsfield, NH 03263
Office (603)435-8030 Fax (603)435-8107
Email smile@pittsfieldnh-dental.com

Request for Records

I, _____ , request the office of _____

to forward x-rays to the above contact.

For Patient: _____ DOB: _____

For Patient: _____ DOB: _____

For Patient: _____ DOB: _____

_____ _____

Signature of Patient/Legal Guardian Date