PERRY FAMILY
DENTAL CARE

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name: _____

Date of Birth: _____

I, _____, understand that my medical record contains confidential medical information. If I have discussed certain sensitive information with my provider, my medical record may also contain reference to this information. Sensitive information includes alleged or actual drug/substance abuse; testing/treatment of AIDS or HIV; or treatment of other conditions. This information is being released at my request.

I hereby authorize release of my medical record from _____ to Perry Family Dental Care. Please email my records to: peterboro.appointment@perrycare.com

The purpose of this release is for:

___ Treatment by another provider

___ OTHER: _____

Information to be released:

___ Entire Record

___ OTHER: _____

I have carefully read this form and I wish to have the designated information released, including that concerning any sensitive information discussed with my provider such as: drug/substance abuse, AIDS, HIV, or any other condition. I will not hold this practice, its health care Providers, or Perry Family Dental Care and its staff responsible for any misuse of this information, which may occur.

_____ _____

Date Signature (patient or guardian)

_____

Witness

Perry Family Dental Care
Dental Benefits Plans
Information

Dental benefits plans are constantly changing, and it is ultimately your responsibility to know your plan and to keep track of the amount of your remaining benefits. Plans and yearly benefits differ from individual to individual, even within the same company. Many dental benefits providers communicate only to you, and not to us. Benefits providers send you the amount of benefits you have used, and the benefits that you have remaining for the year.

When choosing a benefits plan, there can be many differences and plans aren't "one size fits all" anymore. There are different coverages, limits, and waiting times. Choose a plan that has the right coverage for you. Read the "fine print" but realize that many times it is impossible to fully understand the costs. Some of our patients have found that dental plans are not worth the expense and save money every year by not purchasing them.

If your employer purchased your dental plan, talk with your HR department to ensure that you fully understand your policy and your coverage. Benefits providers don't readily share all information on your coverage.

We can all hope that the dental benefits industry will change and become better for everyone, but for now, enjoy the benefits you do receive, realizing they will not fully cover your treatment. We can tell you what we charge for treatment, but we cannot guarantee to you what your benefits will cover.

Our estimates of coverage with your dental benefits are only estimates and are not a guarantee. Eligibility, policy provisions, and subjective decision-making affect coverage, and previous charges from other dental offices affect remaining benefits.

In summary your plan may not pay the full estimated benefit. You are responsible for all frequency limitations and treatment not paid for by your benefits provider.

PERRY FAMILY
DENTAL CARE

Child's Name: _____ Date: _____
Child's Nickname: _____ Physician's Name: _____
Child's DOB: _____ Physician's Phone: _____
Best Contact Number:_____ Date of last physical exam: _____

Has the child had any history of or difficulty with any of the following?

□ Anemia	□ Diabetes	□ Mastoid
□ Asthma	□ Epilepsy	□ Measles
□ Bladder	□ Fainting	□ Mononucleosis
□ Cancer	□ Hearing	□ Mumps
□ Cerebral Palsy	□ Heart	□ Rheumatic Fever
□ Chicken Pox	□ Kidney	□ Thyroid
□ Chronic Sinus	□ Liver	□ Tuberculosis
□ Convulsions	□ Malignancies	□ Venereal Disease

Does the child have any disease or condition not listed above? _____
Is the child currently taking any medications? Please list: _____
Has the child ever had surgery or been hospitalized? Please explain: _____
Does the child have any allergies, including drug allergies? Please List _____
Does the child have good physical coordination? _____
Does the child have any emotional problems? _____
Does the child have any problems with excessive bleeding? _____

In the event your child, under the age of 18, is in our office unaccompanied by a parent or legal caregiver, would you please sign the following release form.

I understand that unforeseen treatment is sometimes necessary due to additional decay. If I do not accompany my child to the appointment to discuss possible treatment changes that can occur during the appointment, I give Perry Family Dental Care and Associates permission to provide the treatment that they consider most appropriate at the time.

Also,

□ I give permission to take x-rays when indicated

□ I give permission to utilize nitrous oxide when necessary

□ I give permission to apply topical fluoride when indicated

Signature_____

Emergency contact name and phone number: _____

Dentist Signature and Date_____

Perry Family Dental Care
Child Registration

_____ _____ _____
Child's Name Date Name they wish to be called by our staff

_____ _____
Email Address for Confirming Appointments Phone # for Confirming Appointments

_____ _____ ☐ Male ☐ Female
Age Date of Birth

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ _____ _____
Child's Dental Insurance & Claim Address Child's ID # Child'S Group Number

_____ _____ _____
Mother's Name Home Phone Number Date of Birth

_____ _____ _____
Mother Employed By Business Phone Number Social Security Number

_____ _____ _____
Mother's Dental Insurance & Claim Address ID Number Group Number

_____ _____ _____
Father's Name Home Phone Number Date of Birth

_____ _____ _____
Father Employed By Business Phone Number Social Security Number

_____ _____ _____
Father's Dental Insurance & Claim address ID Number Group Number

_____ _____
Person Financially Responsible Relationship to Child

Please confirm my appointments at: ☐ Home phone # ☐ Cell Phone # ☐ Email Address

How did you hear about our office?
☐ Google ☐ Facebook ☐ Website ☐ Other_____
☐ Friend/Relative (list name so we may thank them)_____

Dental History

How long since you have had a cleaning? _____Any Xrays taken?_____
Any unhappy dental experiences? _____
Any injuries to mouth/teeth/head?: _____
Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing bottle, pacifier) _____
Any orthodontic appliances being worn now or in the past?_____
What's your child's attitude towards dentistry? _____

Perry Family Dental Care
Financial Responsibility and Consent To Treatment

Two frequently asked questions are “How much will it cost” and “How can I pay for it?” Before we begin with your treatment, we will provide for your review and approval either a verbal or written explanation of the recommended treatment and an estimate of the fees involved. Your acceptance of treatment and financial responsibility is documented prior to treatment.

The following is our office policy regarding payment for dental services rendered:

- Payment in full is expected at each visit.
- Patients with dental insurance are expected to pay their patient portion at time of treatment.
- Any charges left outstanding after 60 days will be assessed a finance charge of 2.34% per month. This is an annual percentage rate of 28%.
- If you are unable to pay for treatment in full, we have financing options that are available, upon credit approval. We do not offer monthly billing within the office, but we work with outside finance companies that upon credit approval, can give you monthly billing options.
- We take the following forms of payment: Cash, Check, Money Order, MasterCard, Visa, American Express, Discover, and Care Credit.
- In order for us to submit bills to your insurance plan, you must provide us with the name, address, subscriber identification number, group number, subscriber’s date of birth, and phone number of the insurance plan prior to your treatment.
- We will assist you in submitting bills to your insurance plan, but you will remain fully responsible for any and all amounts not paid by your insurance plan within sixty (60) days of service. In the event we subsequently receive payment from your insurance plan, we reserve the right to apply any payment to existing unpaid balances.
- If we submit bills to your insurance plan, you agree to pay the full patient portion at the time of service for treatment provided. If your plan pays less than our original estimate given at the time of service, you agree to pay the unpaid portion that is determined by your plan as your actual patient portion.
- We will provide monthly statements for unpaid balances through ninety (90) days. All accounts unpaid after ninety (90) days will be deemed past due and may be sent to a collection agency. You agree to pay all finance charges and costs of collection, including reasonable attorneys’ fees we reserve the right to charge for appointments missed or cancelled without 48 hour notice. We also reserve the right to have you pre-pay for an appointment if you have had a history of missed appointments.
- Unless altered by a divorce decree or child support order, NH law provides that both parents are jointly and severally responsible for treatment provided to their children. Unless you provide us with a valid court order to the contrary, we reserve the right to pursue either or both parents in the event of non-payment for services rendered to a child.
- Notwithstanding the foregoing, the undersigned parent agrees to bear primary responsibility and to serve as the contact person in connection with his/her child’s or children’s account.
- All insurance companies have limitations, and most do not cover 100% of the fee of service. We are considered “in-network” only with Northeast Delta Dental, but will gladly submit claims for almost all insurance companies. You agree to full responsibility for knowing your insurance benefit program and the limitations of your insurance as it applies to coverage, frequency limits, maximums, deductibles and the usual and customary allowance of fees.
- In the event that your insurance plan sends reimbursement directly to you, the office of G. A. Perry, DDS, Professional Association is not responsible for the submission of your dental claims and you must submit your claims yourself.

Patients acknowledge and consent:

- I hereby give my consent to be treated on an ongoing basis by the dentists and other clinical personnel of G. A. Perry, DDS, Professional Association. I understand that I have the right to revoke this consent in writing, at any time, except to the extent that a dentist or other clinical provider has taken action in reliance on my consent previously given. I have read and understand and I agree to the financial terms and conditions set forth above.
- I hereby authorize any insurance benefits to be paid directly to G. A. Perry, DDS, Professional Association and recognize my responsibility to pay for all non-covered services.
- I also authorize G. A. Perry, DDS, Professional Association to release any information necessary to process an insurance claim or to otherwise obtain payment for services rendered.

Please Print: Name of Patient or Dependent(s) _____

Please Sign: Signature of Patient or Parent or Personal Representative: _____
(If younger than 18years of age Parent or Legal Guardian needs to sign)

DATE _____

Perry Family Dental Care

Consent For Use And Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Your Name and Date of Birth _____

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. The Notice is posted in our reception area. Our Notice provides a description of our 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. 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.

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 our office. 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.

SECTION C:

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 a personal representative **on behalf of the patient** signs this Consent**, complete the following:**

PRINT: Personal Representative's Name:

Relationship to Patient: Mother Father Spouse Grandparent Caretaker OTHER _____

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

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ Date _____

UPDATED September 23, 2013

MISSED APPOINTMENT AGREEMENT FOR PERRY FAMILY DENTAL CARE

We make every effort to value your time and we schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

We will not charge for your first missed appointment. However, after two missed appointments in a 12 month span, you will be required to pay a $100.00 deposit when scheduling the next appointment. If you keep the appointment the deposit will be applied towards treatment. However, if you fail to keep the appointment a second time, the prepayment will be forfeited.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Please let us know if you have any questions.

Appointment Agreement:

- I acknowledge an appointment is a reservation. Initials _____
- I agree to provide a minimum of 48 hours notice if I need to change my appointment for any reason. Initials _____
- If I fail to keep two appointments in a 12 month span, I acknowledge I will be asked to pay a deposit of $100.00 when scheduling the next appointment. Initials _____

_____ _____

Patient Signature ***Date***