ROCKAWAY DENTAL CENTER

1) PATIENT INFORMATION

Patient Full Name_____ SS# _____

Birth Date_____ Age_____ Male or Female

Address _____ City _____ State___ Zip_____

Employer_____ Occupation_____

Previous Dentist _____ Phone_____

Current Physician_____ Phone_____

Whom may we thank for referring you?_____

2) TELEPHONE & EMAIL

Home_____ Work_____ Cell_____

Email_____

In the event of an emergency, who should we contact?

Name_____ Relationship_____

Home_____ Work_____

3) RESPONSIBLE PARTY

Who is responsible for this patient?

Full Name_____ SS#_____

Are you? Single Married Widowed Divorced

Birth Date_____ Age_____ Male or Female

Address _____ City _____ State___ Zip_____

Employer_____ Occupation_____

Home_____ Work_____

4) INSURANCE INFORMATION

Dental Coverage? Yes or No

Insured's Name_____ Relation_____

Insured's SS#_____ Birth Date_____

Insured's Employer_____

Insurance Group #_____ Insured's ID#_____

Insurance Co. Name_____ Phone_____

ROCKAWAY DENTAL CENTER

5) DENTAL HISTORY

Do you require antibiotics before dental treatment?..... Yes___ No___
Do your gums ever bleed?..... Yes___ No___
Do you or have you ever experienced pain in your jaw joint (TMJ/TMD)? Yes___ No___
Do you brush/floss on a regular basis?..... Yes___ No___

6) MEDICAL HISTORY

Are you taking any medications?..... Yes___ No___
If so, please list here?_____
Are you allergic to any medications?..... Yes___ No__
If so, please list here?_____
(Women) Are you pregnant?..... Yes___ No__
If so, how many weeks? _____
(Women) Are you nursing?..... Yes___ No__
(Women) are you taking birth control?..... Yes___ No__
Are you allergic to aspirin?..... Yes___ No___
Are you allergic to dental anesthetics?..... Yes___ No___
Are you allergic to erythromycin?..... Yes___ No__
Are you allergic to latex or rubber products?..... Yes___ No___
Are you allergic to penicillin?..... Yes___ No___
Any other medical information we should need to know? Or recent surgeries/procedures?_____

CHECK ALL THAT APPLY

Alcohol/Drug Abuse.....	Yes___ No___	Hepatitis.....	Yes___ No___
Anemia.....	Yes___ No___	Herpes/Fever Blister	Yes___ No___
Asthma.....	Yes___ No___	High Blood Pressure	Yes___No___
Cancer.....	Yes___ No___	HIV/AIDS.....	Yes___No___
Diabetes.....	Yes___ No___	Low Blood Pressure...	Yes___ No___
Emphysema.....	Yes___ No___	Pacemaker.....	Yes___ No___
Epilepsy/Seizures.....	Yes___ No___	Rheumatic Fever....	Yes___ No___
Fainting Spells.....	Yes___ No___	Sinus Problems.....	Yes___ No___
Frequent Headaches.....	Yes___ No___	Stroke.....	Yes___ No___
Heart Attack.....	Yes___ No___	Thyroid Problems....	Yes___ No___
Heart Murmur.....	Yes___ No___	Tuberculosis.....	Yes___ No___
Hemophilia.....	Yes___ No___	Ulcers.....	Yes___ No___

4) ACKNOWLEDMENT & AUTHORIZATION

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____
Signature Date

ROCKAWAY DENTAL CENTER

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, through, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit claims on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office submit your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this for and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or question that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO ROCKAWAY DENTAL CENTER, ADAM HELFAND DMD.

_____ _____

Signature of Patient/Responsible Party Date

I AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.

_____ ____/____

Print Name on Card Expiration Date

_____ _____

Credit Card Number V-Code

ROCKAWAY DENTAL CENTER

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. Your insurance policy is contract between you, your employer, and the insurance company. Our office is not party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement.

Payment is due at the time of service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express or Care Credit.

Return checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 3.75% per month (45% annually). Additionally, our office will charge you for broken appointments and appointments cancelled without 24-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____

Print Name

_____ _____

Signature Date

Appointment Cancellation/No Show Agreement

At Rockaway Dental, Our goal is to provide personalized quality care to each of our patients in a timely manner. Our appointment cancellation and no show agreement was created to allow us to utilize our appointment times for patients in need of care.

Appointment Cancellation

We schedule appointment times specifically for each patient so we may provide services to the best of our ability.

Please schedule carefully and if you must reschedule, please provide us with ***at least 24 hours notice to avoid a charge to your account.*** This notice allows us to contact patients who are on a waiting list for last minute or emergency appointments. To cancel or reschedule an appointment please call our office or email us and we will reschedule your appointment.

Last Minute Cancellations/ No Shows/ Late Arrivals

- Late arrivals can create scheduling issues for the other patients. Please notify us as soon as possible if you anticipate arriving late so we can accommodate everyone accoridngly.
- No Show and last minute cancellations prevent us fromoffering services to other patients in need and will be recorded in your chart. Two last minute cancellations or no shows will result in a charge to your account.

Your understanding and cooperation is greatly appreciated. If you have any questions please ask a staff member for clarification on our policies.

_____ _____

Patient or Guardians Signature Date

ROCKAWAY DENTAL CENTER

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____ _____

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)**

_____

_____

_____