Date _____

Patient Registration

Please PRINT clearly. Thank you!

PATIENT INFORMATION
Tell us about yourself!

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)-_____-_____

Cell/Other Phone: (_____)-_____-_____

Business Phone (_____)-_____-_____

Email Address: _____

Sex: M F Age: _____ Birthdate: _____/_____/_____

Single Married Divorced Widowed Separated

Social Security Number: _____-_____-_____

Employer: _____

Employer Address: _____

Occupation: _____

Who may we thank for referring you? _____

WHO IS RESPONSIBLE?
If the patient is responsible for the bill, there is no need to fill out this box. If someone other than the patient is responsible, please fill out this box thoroughly.

Name: _____

Relationship to the patient: _____

Social Sec. Number _____-_____-_____

Birthdate: _____/_____/_____

Contact Phone: (_____)-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Payment in full is expected at the time of service. Insured patients: co-pays and deductibles are due at the time of service. Should any out off pocket costs occur, I will be paying today by:

☐ Cash ☐ Check ☐ Visa ☐ MasterCard

Charge Card Authorization: I hereby authorize Dr. David Rosh to bill my charge card account should any balance for services rendered remain outstanding for more than (60) sixty days. If the account information given expires or is discontinued, I agree to give Dr. David Rosh information of an alternate charge account, which may be used. My account information is as follows:

Card # _____ Exp. _____

Signature _____ Date _____

EMERGENCY CONTACT/GUARDIAN INFORMATION

Incase of an emergency please contact: _____

Phone: (_____)-_____-_____

Relationship to the patient: _____

Guardian/Parent Name:_____

Guardian/Parent Birthdate: _____/_____/_____

Guardian/Parent Social Security: _____-_____-_____

Guardian/Parent Employer: _____

Guardian/Parent Phone: (_____)-_____-_____

MINOR/CHILD CONSENT: *I, being the guardian of the above patient, authorize the office of Dr. David Rosh and staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.*

X _____ Date: _____/____/_____

DENTAL INSURANCE
(Please advise us if you have secondary coverage.)

Policy Holder: _____

Employer: _____ Group#_____

Relationship to the patient: _____

Policy Holder's Phone: (_____)-_____-_____

Policy Holder's Social Security: _____-_____-_____

Policy Holder's Birthdate: _____/_____/_____

Insurance Company: _____

ASSIGNMENT AND RELEASE (Please read and sign.)

I, the undersigned, have insurance and assign directly to Dr. David A. Rosh all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. ***I understand that all co-payments and deductibles are due at the time of treatment.***

X _____ Date: _____/_____/____

ACKNOWLEDGE AND RECIPT OF NOTICE OF PRIVACY PRACTICES

(Health Insurance Portability and Accountability Act)

I, _____ have had the opportunity to view the Notice of Privacy Practices of this office. This Notice of Privacy Practices presents the information that federal law requires this office to make available to me upon my request.

X _____ Date: _____/____/_____

Signature of Patient/Parent/Guardian

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (If YES, check boxes that apply):

☐ Heart Problems	☐ Back Problems	☐ Psychiatric Care	☐ Special Diet
☐ High Blood Pressure	☐ Diabetes	☐ Chronic Diarrhea	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Respiratory Disease	☐ Allergies to Anesthetics	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Epilepsy	☐ Allergies to Medicine or Drugs	☐ Sinus Problems
☐ Nervous Problems	☐ Headaches	☐ General Allergies	☐ HIV/AIDS Or Other Immunosuppressive Disorders
☐ Radiation Treatment	☐ Hepatitis—Type: _____	☐ Blood Disease	
☐ Artificial Heart Valves or Joints	☐ Liver Disease	☐ Arthritis	☐ Stroke
	☐ Cancer	☐ Chemical Dependency	☐ Ulcer
☐ Recent Weight Loss	☐ Jaundice	☐ Venereal Disease	☐ Hemophilia

Do you smoke? ☐ Yes ☐ No How often/much? _____ Do you drink alcohol? ☐ Yes ☐ No How often/much? _____

Do you have any drug allergies to any medications? ☐ Yes ☐ No If so, what _____

Have you ever had an adverse reaction to any medication? ☐ Yes ☐ No If so, what _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? ☐ Yes ☐ No If so, what _____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

Women: Are you are pregnant? ☐ Yes, _____ months ☐ No Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance of benefits for which I am entitled. I will not hold my dentist or any other member of his/her staff responsibilities for any errors or omissions that I may have made in the completion of this form.

Date: _____/_____/_____ Signature: _____

DENTAL HISTORY

Date of Last Dental Visit: _____/_____/_____ What was done at that visit? _____

Previous Dentist's Name: _____ Address: _____

How often do you have dental exams? _____ How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe: _____

Are your teeth sensitive to:
Biting or Chewing? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Hot or cold? ☐ Yes ☐ No

Have you ever had:
Orthodontic treatment? ☐ Yes ☐ No
Oral surgery? ☐ Yes ☐ No
Periodontal (Gum) treatment? ☐ Yes ☐ No
Tired jaws, especially in the morning? ☐ Yes ☐ No

Have you ever experienced:
Clicking of the jaw? ☐ Yes ☐ No
Pain in the joint or ear? ☐ Yes ☐ No
Difficulty opening or closing the mouth? ☐ Yes ☐ No
Difficulty chewing? ☐ Yes ☐ No
Do your gums bleed when you brush or floss? ☐ Yes ☐ No
Do you notice any loose teeth or change in your bite? ☐ Yes ☐ No
Do you clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Have you ever had an upsetting dental experience? ☐ Yes ☐ No - If yes, please describe: _____

_____

Is there anything else you want us to know? _____

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)

David A. Rosh, D.M.D., P.C

Gentle, caring dentistry for the whole family.

OUR POLICY OF CARE AND PAYMENT

Dear New Patient:

We would like to welcome you to our fine dental practice and explain a little about our office policies and goals. We believe the theories of Modern Dental Care, which do not support the old premise of "when it hurts – fix it". Through proper and preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep a healthy smile for all their lives.

Our patients can expect from us ☺ A high degree of professional skill and ability. ☺ A dedication to your oral health and privacy. ☺ The highest effort to make your visits as comfortable as possible. ☺ The right treatment at the right time. ☺ Fees that are fair for the services provided.

In return, we expect our patients ☺ Cooperation in making and keeping appointments. **(At least 24-hour cancellation notice is required) We reserve the right to charge a fee for patients who do not show, or cancel the day of appointment**. ☺ A conscientious effort toward good oral health. ☺ Recall visits to maintain optimum oral health. ☺ A definite arrangement for payment of fees at the time of service.

We feel that the best investment anyone can make is to prevent the pain and discomfort associated with advancing oral disease, and to save costly expenses often connected with the reconstruction of the damages that do occur through neglect. In order for our newly formed relationship to me mutually satisfying and beneficial, we ask that anytime you have a question or are unhappy about any treatment (proposed or preformed), fee for service, or attitude from our Dental Team, please discuss it with us promptly and openly. Misunderstanding and/or lack of communication are only obstacles to our continued friendship and professional relationship.

Best Personal Regards,

David A. Rosh & Staff

☺ **Insured Patients**: **Please carefully review and sign the Insurance Policies form.**
Please note: Although we accept the assignment of your insurance company to lessen the financial impact of your dental care, account guarantors are ultimately responsible for the account in full. Payment for deductibles, co-payments, and non-covered procedures are due at the time services are rendered.

☺ **Non-Insured Patients: Payment in full is expected when services are rendered.**

We accept Visa, MasterCard, personal check or cash. In the event of default in payment, **after 90 days,** account guarantors agree to pay **1.5%** per month on the unpaid balance. We reserve the right to take legal action on accounts that qualify. Account guarantors are responsible for court and attorney fees.

X _____

Patient / Parent / Guardian Please Sign

David A. Rosh, D.M.D., P.C

Gentle, caring dentistry for the whole family.

Office Insurance Policy For All Patients

PLEASE UNDERSTAND that we file insurance claims as a **COURTESY** to our patients. When you provide us with all necessary information, we will be happy to file insurance claims for you.

YOU MUST REMEMBER that insurance benefits belong to you. We will not be held responsible for understanding how your insurance works. We offer assistance with insurance matters as a **COURTESY** to our patients.

AT NO TIME CAN WE GUARANTEE what your insurance will or will not cover for any service. We can only assist you in estimating your portion for the cost of treatment based on the information we have on your plan.

PLEASE BE AWARE that on most insurance plans, white fillings on certain teeth are considered cosmetic, and you're out of pocket expense may be more than our office has estimated. Call your insurance carrier for further details.

WE DO NOT DICTATE YOUR COVERAGE. The type of contract your employer has set up with the insurance company determines the amounts paid for services.

PLEASE UNDERSTAND THAT INSURANCE DOES NOT MEAN, "FREE". Although we accept the assignment of your insurance benefits to lessen the financial impact of your dental care, you are ultimately responsible for the account in full.

YOU ARE RESPONSIBLE FOR knowing how your insurance works. You must be familiar with your insurance benefits, as we will collect all estimated co-pays and deductibles at the time of service.

MOST IMPORTANTLY, you must keep us informed of any insurance changes such as policy name, insurance company address, or a change in employment.

YOU MUST contact your insurance carrier or employer with any insurance inquiries.

I have read the above insurance policy, and agree to all conditions.

X _____

Signature Patient/Parent/Guardian

Newbury Common
1450 Washington Boulevard, Suite 105
Stamford, CT 06902
Phone: 203-359-2244 • Fax: 203-323-9098