PATIENT REGISTRATION

PATIENT NAME (PLEASE PRINT):	SEX:	DATE OF BIRTH:
STREET ADDRESS:	CITY:	STATE: ZIP:
RESPONSIBLE PARTY NAME (IF MINOR):	RELATIONSHIP:	
MOBILE PHONE NO:	HOME PHONE NO:	
E-MAIL ADDRESS:		
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE NUMBER:
HOW DID YOU HEAR ABOUT OUR PRACTICE?		

INSURANCE INFORMATION

IF YOU WISH FOR US TO PROCESS INSURANCE CLAIMS ON YOUR BEHALF, COMPLETE THIS PORTION AND SIGN BELOW:

PRIMARY INSURANCE CARRIER:		SECONDARY INSURANCE CARRIER:	
EMPLOYER'S NAME:		EMPLOYER'S NAME:	
SUBSCRIBER NAME:	DOB:	SUBSCRIBER NAME:	DOB:
SUBSCRIBER POLICY NO:		SUBSCRIBER POLICY NO:	
PATIENTS RELATIONSHIP TO SUBSCRIBER:		PATIENTS RELATIONSHIP TO SUBSCRIBER:	
INSURANCE ADDRESS:		INSURANCE ADDRESS:	
GROUP PLAN NAME:	GROUP PLAN #:	GROUP PLAN NAME:	GROUP PLAN #:

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE INSURANCE PAYMENTS BE MADE DIRECTLY TO THE DENTAL OFFICE. I ACKNOWLEDGE AND AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES NOT PAID BY MY INSURANCE CARRIER. I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

SIGNATURE: _____ DATE: _____

ELECTRONIC COMMUNICATION:

Accept _____ I agree to receive electronic communication from the practice. I agree to receive text messages, emails and voicemail.
Please note:

- When you opt in to receive SMS messages, we collect your phone number and your consent to send SMS messages ONLY
- Messaging and data rates may apply
- Message frequency may vary
- We use your information to send you the SMS messages you've opted in to receive and provide updates, promotions, or other relevant content based on your preferences
- We do not share your phone number or SMS opt-in information with third parties for marketing purposes
- We implement reasonable measures to protect your personal information from unauthorized access or disclosure
- You can opt out of receiving SMS messages at any time by replying with "STOP" to any message we send you
- If you have questions or concerns about our privacy practices, contact our office

Decline _____ I do not wish to receive any electronic communication. Please note: If you decide to opt-in, please notify our team.

MEDIA:

Accept _____ I authorize full permission to use images taken of myself/my child. I understand that I can revoke this release, in writing, at any time. We will use the following social media platforms:

- Facebook
- Instagram
- TikTok
- Website
- Google Business Listings/Reviews

Decline _____ I do not authorize the use of any images taken of myself/my child

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
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
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

OFFICE & FINANCIAL POLICIES

Welcome to our Practice. Our goal is to provide exceptional dental care for you and your family in a relaxed and pleasant environment. To provide you with a full understanding of our office and financial policies, kindly review and sign below. We appreciate the opportunity to serve you and thank you for choosing us to take care of your dental needs.

FINANCIAL POLICY: (please initial) _____

To provide the best service possible, payment, including deductibles and the estimated amount not covered by your insurance will be due at the time of service.

For your convenience, we accept cash, personal checks, Visa, Mastercard, Discover, American Express, and Care Credit. Third Party Financing is subject to credit approval and additional fees may apply.

Due to contractual obligations, we are required to charge fees based on the insurance company's determinations and third-party financing. No additional discounts can be applied.

A service fee of $35 will be applied to the account for handling any returned checks.

If your account becomes delinquent, it may be forwarded to an outside collection agency. If this happens, you will be responsible for all costs of collection, including but not limited to, interest, rebilling fees, court fees, attorney fees, and collection agency costs.

INSURANCE POLICY: (please initial) _____

If you have insurance benefits, we will gladly submit claims are your behalf. Your estimated copayment (the amount not covered by your insurance) for treatment is due at the time treatment is provided.

If you fail to provide the required insurance information, we will ask that you pay the bill in full at the time treatment is provided. If insurance is provided post procedure, and within the insurance company's statute of limitations, we will submit a claim on your behalf and reimburse once payments have been made.

As a courtesy, we will contact your insurance company, however, we are not responsible for inaccurate estimates (written or verbal) of coverage given to us by your insurance company. If coverage is denied, for any reason, you will be responsible for payment of the full cost of the treatment rendered and any outstanding amount.

Our office will not enter into a dispute with your insurance company over any claim. We will, however, provide the necessary documentation your insurance company requests to settle the claim.

APPOINTMENT POLICY: (please initial) _____

Operative rooms, instruments, and personnel are reserved exclusively for your appointment. There is a $50 charge for canceled, missed (No Show), or rescheduled appointments with less than 24 hours' notice. Repeated instances of failed appointments without 24 hours' notice will result in dismissal from the practice.

I have read, understood and agree to the terms and conditions stated in this policy.

Responsible Party Name: _____ Date _____

Responsible Party Signature: _____ Date _____

Patient Name (print): _____

Sturbridge Dental

GENERAL DENTAL TREATMENT CONSENT

PLEASE READ AND INITIAL BELOW

It is very important to provide your dentist with accurate information before, during, and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medications, pre- and post-treatment instructions, referrals to other dentists or specialists, and to return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Noncompliant patients may be dismissed from the practice.

_____**EXAMINATION, PREVENTATIVE CARE, TREATMENT, AND X-RAYS** I understand that during my course of treatment that the following care may be provided: examinations, preventative services, diagnosis, basic restorative, and crowns. I understand that my initial visit and periodically thereafter, or as needed, I may require radiographs in order to complete the examination, diagnosis, and treatment plan.

_____**DRUGS AND MEDICATIONS** I understand that I may receive a local anesthetic and/or other medication. In rare instances, patients may have a severe reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing or aspirating foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

_____**BASIC FILLINGS AND RESTORATIONS** I understand that I may experience hot and cold sensitivity, pain, or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs. I understand that care must be exercised in chewing on the new filling during the first 24 hours to avoid breakage.

_____**CROWNS, BRIDGES, VENEERS, AND BONDING** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge, or veneer (including shape, fit, size, placement, and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

_____**GENERAL RISKS OF DENTAL PROCEDURES** General risks include (but are not limited to) complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks, and teeth; thrombophlebitis (inflammation to a vein), change in occlusion (biting), muscle cramps, and spasms; temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues; and referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery.

_____**CHANGES IN TREATMENT PLAN** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

_____**ALTERNATIVES** I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. I have no further questions.

_____

Patient Name (Please Print) Date

_____

Patient or Parent/Guardian Signature Relationship to Patient Date