SCOTT F. BOBBITT, DMD, MAGD, PA
76 Allds Street, Suite 6, Nashua, NH 03060-4758 (603) 882-3001

Patient Registration Information

Patient Name____ Date:________________
Last, First MI (Preferred Name)

Address: ____

Email address: ______________________ (we only use this for our communications with you)

Social Security #: ______________________ Birth Date: ______________________

Driver's Lisc #:______________________

Phone (Home):______________ Pager or Cell Phone # ______________ Best time to call: ______________

Employer: ____

(Work): ______________ Ext: ______________

Full Time College Student? If yes, University/College name/City, State: ________

Preferred appointment times: ☐ **Morning** ☐ **Afternoon** ☐ **Any Time** ☐**Mon** ☐**Tue** ☐**Wed** ☐**Thu**

Insurance Information
Primary
Insurance Plan Name and Address:

Subscriber:________________________________Is subscriber a patient? ☐ Yes ☐ No
Last First MI
Subscriber's Birth Date: ____________ ID #: ______________ Group #:______________

Subscriber's Address______________________________________
Street City State Zip Code
Subscriber's Employer:______________________________________

Employer Address: ______________________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Secondary
Insurance Plan Name and Address: ______________________________________

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Subscriber:________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI
Subscriber's Birth Date: ____________ ID #: ______________ Group #:______________

Subscriber's Address:______________________________________
Street City State Zip Code
Subscriber's Employer: ______________________________________

Employer Address: ______________________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Authorization and Release

I am authorized and do grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. This signature on file is my authorization for the release of information necessary to discuss treatment recommendations or referral discussions with other health practitioners. It also authorizes Scott F. Bobbitt, DMD, Professional Association to process claims, including any information regarding the diagnosis, records of any examination or treatment rendered during the period of such dental care to third party payers and/or other health practitioners. I hereby authorize payment of the insurance benefits for services rendered, otherwise payable to me, to: Scott F. Bobbitt, DMD, Professional Association. To the best of my knowledge, all of the preceding information provided is true and correct. When any change(s)occur, I will take the responsibility to inform the administration as soon as possible, but before my next appointment so that my records are always current and up to date.

X______________________________ Date: __________ Relationship to Patient: ____________
Signature of patient, parent or guardian

MEDICAL HISTORY

(PERSONAL AND CONFIDENTIAL)

Name: ____

Date of Birth: ________/______/__________

Please Circle

1. Are you under the care of a physician? ………………………………………………………….…………….. Yes No
    a. If yes, for what treatment or reason: ____
    b. Primary Care Physician's (PCP) Name: ____
    c. Primary Care Physician's (PCP) Address: ____
    d. Date of last physical: ____
    e. Are you in good health? ……………………………………………………………………………… Yes No
2. Have you been hospitalized in the last five (5) years: ……………………………………………….……… Yes No
    a. When? ______________ Reason? ____
3. Are you taking any medications? (prescription, over-the-counter, herbal, illicit, vitamins, other)……….... Yes No
    a. If yes, please list here: ____
4. Have you had an allergic reaction to any medication, metal, latex or jewelry? …………….…………… Yes No
    a. If yes, which ones? ____
5. Have you ever used diet drugs (*e.g.* Redux, Phenfen) …………………………………..………………. Yes No
    a. If yes, have you had an ultrasound heart exam? ………………………………….……………….. Yes No
6. Have you had trouble with prolonged bleeding after surgery? …………………………….……….…… Yes No
7. Have you ever been diagnosed with cancer or a tumor? ……………………………….……….….…. Yes No
    a. If yes, what was your diagnosis: ____
    b. Did you receive chemotherapy? ………. Yes No Radiation therapy? ……………………..... Yes No
    c. Date of last treatment: Month _____________ Year___________
8. Have you ever taken medications for osteoporosis? …………..…………………………………….…… Yes No
9. Have you ever used tobacco products? ……………………………………………………………...….... Yes No
    a. If yes, how much did/do you smoke? __________ Packs per day for _______Years
    b. If you are an ex-smoker, what year did you quit? ________________________
    c.
10. Please circle "Yes" or "No" for any of the following conditions you may have or have had in the past:

Condition			Condition			Condition		
Heart Attack …………....	Yes	No	Penicillin Reaction …….	Yes	No	Hepatitis ……..……...	Yes	No
Heart Murmur ………....	Yes	No	Snoring ………………...	Yes	No	AIDS/HIV ……............	Yes	No
Heart Valve Problem…..	Yes	No	Sleep Apnea …………...	Yes	No	HPV …………………...	Yes	No
Rheumatic Fever …….....	Yes	No	Daytime Sleepiness …...	Yes	No	Substance Abuse ………	Yes	No
Heart Disease ………......	Yes	No	Kidney Trouble …….....	Yes	No	Blood Transfusion…..…	Yes	No
Heart Surgery ……….....	Yes	No	Thyroid Problem..……...	Yes	No	Anemia ………………...	Yes	No
High Blood Pressure …...	Yes	No	Asthma ………………...	Yes	No	Bruise Easily ………....	Yes	No
Pacemaker ... ……….....	Yes	No	Arthritis …………….....	Yes	No	Bleeding Problems …....	Yes	No
Angina Pectoris ……..…	Yes	No	Allergies/Hives ………....	Yes	No	Psychiatric Care …….....	Yes	No
Stroke ………………….	Yes	No	Emphysema ……….....	Yes	No	Anxiety/Depression ……	Yes	No
Diabetes ………...........	Yes	No	Dry Mouth ……..……...	Yes	No	Epilepsy/Seizures ……...	Yes	No
Ulcers ………….……......	Yes	No	Gum/Mouth Surgery …..	Yes	No	Fainting/Dizziness ….....	Yes	No
GERD/Reflux/Heartburn .	Yes	No	Cold Sores ……….….....	Yes	No	Artificial Joints ………....	Yes	No

11. Do you have any disease, condition or problem not listed above? ……………………………….…....Yes No
    a. If yes, please list here: ____
12. **WOMEN:** Are you pregnant? … Yes No Nursing? ……Yes No Taking Birth Control Pills? ... Yes No

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To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change(s) in my health, I will inform the doctor at the next appointment without fail.

X____ **Date:** ____________ **Staff:** ____________

(Signature of patient, parent, or guardian)

FOR STAFF USE

SCOTT F. BOBBITT, DMD, MAGD, PA FINANCIAL POLICIES 2011

(This supersedes all Financial Policies and Options prior to this date and is effective 1/1/2010)

Payment: Payment for services is required on the day dental services are rendered. We offer numerous ways for you to handle the financial responsibility of your dental care. We offer more options now than ever before which we find meet the needs of most individuals and families in our practice. We are here to help you; let us know which one works best for you.

1. **Cash or Check**
2. **Payment by Appointment**: Payments made over 2-3 months for the service. (Approval is required prior to appt.)
3. **Bankcards**: VISA, MasterCard, Discover, American Express
4. **Dental Insurance**: We offer the service of filing your dental claim electronically. Your copayment is due at time of service.
5. **Third party financing**: We have 2 financing partners, *Citi Health Card* and *Care Credit* (Application approval is required prior to appt.)

Financial Agreements: Our office provides written ***Financial Information Forms***, to help you understand your financial responsibility for your recommended dental treatment. Once you decide what financial option best suits you, it should be written and approved on a ***Financial Information Form*** when scheduling your appointment. Our administrative staff is here to assist you. Please let them know your concerns.

Dental Insurance: We will process your dental insurance claim electronically one time, using the primary dental insurance information you have given us**. To ensure your insurance information on file is current please provide your dental insurance card *prior to each visit*.** Should you elect to utilize this claim filing service, we request you pay your ***estimated*** co-payments at each appointment. Please be aware of your deductible, co-payments your maximum, and that you will be responsible for any portion the insurance does not cover. We expect dental insurance carriers to make payment to our office within 2 wks of electronic claim submission. If payment from them is not received within 4 weeks or the information you gave us is not current, we reserve the right to request payment in full from you. You are responsible for the account if the insurance company, for any reason, does not honor their commitment to you. We cannot claim responsibility to know the status of your benefits. A nominal service charge is applied to your account in order to submit your claim to a secondary insurance company or for multiple resubmissions to your primary insurance company.

Treatment Plan Changes or Delays due to Complications: It is our intention to plan treatment and inform you completely before we perform services. Due to the nature of dentistry, there are times when planned treatment is changed due to therapeutic complications or unanticipated findings determined during therapy. Time between diagnosis and following through with treatment can be a significant factor. Therefore any delay in scheduling recommended treatment can be cause to affect the outcome of the original treatment recommended. These findings will be brought to your attention, along with any associated changes in treatment and plans. As such, fees listed on treatment plan estimates and financial information sheets may change in the service provided. Please refer to document: Policy on Treatment Completion Delays due to other treatment needs.

Dental laboratory Fees: We request half the total fee at the preparation appointment. This is necessary for all services involving dental laboratory work at the start of therapy, in order to process impressions for crowns, implants, dentures, oral appliances or other lab fabricated items. Unless alternative financial arrangements have been made, any balance is to be paid in full at the ***try-in date*** for partials, dentures, or for large prosthetic cases before final processing.

Senior Citizens: To honor our senior patients without insurance, Dr. Bobbitt would like to extend a courtesy of up to 10% for payment with CASH or CHECK to those who qualify. Courtesies will not be combined with any other courtesies, offers or discounts and are at the discretion of Dr. Bobbitt. To qualify, the patient must:

1. Have attained 65 years of age.
2. Pay for services with CASH or CHECK
3. Pay the entire fee for services at or before the appointment.
4. Carry no balance on account
5. Not have insurance involved in payment coverage for the service(s).
6. No credit card/credit service accepted for this courtesy.

Billing Statements: If you receive a statement from us on a balance due, we ask that you make payment in full upon receipt of the statement and no later than the due date. Should you have any questions regarding your statement, we ask you call our billing administrator immediately to address your concerns. If the balance is not paid in full by the payment due date, we will assess finance charges accordingly. Communication is absolutely imperative should you have questions or need some assistance.

24% APR Finance Charge: If payment is not made in full within sixty (60) days from the date of service, a Finance Charge at the periodic rate of two percent (2%) per month, which corresponds to an Annual Percentage Rate (APR) of twenty four (24%) will be charged against any outstanding balance, regardless of insurance benefits or status of an outstanding claim.

Returned checks/Collection Service: A service charge (amounts are determined by drawing bank) will be applied to your account for checks returned to our office due non-sufficient funds. If it is necessary to place your account with a collection agency, you will be responsible to pay an additional 35% of the outstanding balance to cover our collection costs and you will be dismissed from the practice.

ACKNOWLEGEMENT AND AGREEMENT TO PAY FOR SERVICES RENDERED:

I have read and agree to abide by the financial policies listed above. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Printed Name: **Signature:** **Date:**