DSDG | DR SHARON DENTAL GROUP

36 CONANT STREET #2
DANVERS, MA 01923

T 978.774.1177
F 978.774.1114

WWW.DRSHARONDENTAL.COM
INFO@DRSHARONDENTAL.COM

Welcome to our Practice!

Dear Patient,

On behalf of our team, we want to thank you for placing your confidence and trust in our practice to care for your dental needs and we look forward to meeting you.

We are committed to providing you with the highest quality of oral health care and pride ourselves in making dentistry a pleasant experience in the most gentle and caring way.

Our focus is on preventive care and retention of your natural teeth, however we also provide complete restorative care, full mouth rehabilitation including invisalign, periodontal treatment and implant placement.

During your first visit, the doctor will perform a comprehensive examination consisting of reviewing your medical and dental history, taking any necessary radiograph's, performing an oral cancer screening, examining your teeth and soft tissues and a periodontal health evaluation. The doctor will discuss any findings and recommendations with you at that time.

We appreciate the value of your time and with the exception of emergency situations, will do our best to be on time for you. We appreciate the same courtesy.

Our practice realizes the importance of referrals. Referring a friend or family member is the highest compliment you can give us. Please speak with a member of our team about our referral program.

We are here to help you so please do not hesitate to come to any one of us with any questions and/or concerns.

Respectfully,

Sharon Schrott, DMD

Dr. Sharon Dental Group
36 Conant Street Unit 2
Danvers, MA 01923
T. 978-774-1177
F. 978-774-1114
www.drsharondental.com
info@drsharondental.com

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)

Gender: ______________________________ Family Status: __________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ______________ (Work): ______________ Ext: ________ Best time to call: __________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding

☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease

☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis

☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

Medication List:
☐ ______________
☐ ______________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

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

______________________________ Date: ______________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ______________

Name of person or office referring you to our practice: ______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: _____ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

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

Insurance Plan Name and Address:______________________________

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

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

Insurance Plan Name and Address: ______________________________

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.50% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

Dr. Sharon Dental Group
36 Conant Street Unit 2
Danvers, MA 01923
T. 978-774-1177
F. 978-774-1114
www.drsharondental.com
info@drsharondental.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment *

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining that acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (please specify)

____

DSDG | DR SHARON DENTAL GROUP

36 CONANT STREET #2
DANVERS, MA 01923

T 978.774.1177
F 978.774.1114

WWW.DRSHARONDENTAL.COM
INFO@DRSHARONDENTAL.COM

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires and bad weather do occur. We ask our patients to give us 48 hours notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with 48 hours or more notification – no charge.

Cancellation or rescheduling of an appointment with less than 48 hours and up to 24-hours notice may or may not be considered a broken appointment; it will be at our discretion.

Failure to give at least 24 hour notice:

- We allow for one (1) broken appointment within a 12-month period
- Any additional broken appointments within a 12-month period will be charged a fee as follows:

  $40.00 for a hygiene appointment
  $75.00 for a doctor's appointment scheduled for an hour or less, each additional hour incurs an additional fee of $50.00

A "broken appointment" is when you:

- Cancel or reschedule an appointment with less than 24-hours notice
- Do not show up for the scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. This allows us to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

_____ I have read and understand the above mentioned policy.

______________________________ Patient Signature

______________ Date

DSDG | DR SHARON DENTAL GROUP

Dr. Sharon Dental Group
36 Conant Street Unit 2
Danvers, MA 01923
T. 978-774-1177
F. 978-774-1114
www.drsharondental.com
info@drsharondental.com

Payment Policy Acknowledgement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment of fees:

A. Payment in full by cash, check, debit or credit card, or alternate financing for each appointment as service is rendered.

B. For insurance patients we will accept payment for the initial examination directly from the insurance company for that percentage the company will cover. We gladly accept insurance assignments, but require that the deductible and non-covered fees be paid at each visit. In the event of duplicate payment, you will be reimbursed.

C. Credit cards - Visa, MasterCard, Discover, and American Express - are accepted.

D. Alternate financing (Care Credit) accounts are accepted. We will be glad to assist you in filling out an application. Credit approval is required.

E. For all services payment in full - or your portion of payment if you have insurance - is expected on the date of service, except special payment arrangements have been made in advance.

F. Surgical cancellation fee: When making an appointment for a surgical service, we will collect a security deposit of $300, which will be fully credited to your account at the day of service. In case you don't show up for the surgery or cancel less than 24 hours before the scheduled appointment, we reserve the right to charge you for the full cancellation fee.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered. Our office staff understands dental insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract.

It is important that you realize, however that…

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
2. Our fees generally, but not necessarily, fall within the usual and customary fee structure, determined by your carrier.
3. Not all dental services are a covered benefit in all contracts.
4. You (not the insurance company) are responsible to us for all of our fees for services rendered to you.
5. For patients who have insurance, an ESTIMATE will be given of the benefits that the insurance company is expected to pay, and any co-payment is expected at the time services are rendered.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

______________________________ ________________

Patient or Responsible Party — Date