ESTD 2018

HOMETOWN FAMILY DENTISTRY

Nicholas Ritzcovan, DDS

PATIENT INFORMATION

Date_____

Patient's last name_____ First name_____ Middle initial _____

Title Mr. Mrs. Ms. Miss. Dr. Other_____I prefer to be called _____

Birth date_____ Social Security # _____

Marital Status Single Married Separated Divorced Widowed

Home address_____ City, State, Zip code _____

Home phone ( )_____-_____ Cell phone ( )_____-_____ Work phone ( )_____-_____

Email Address(es) _____

Occupation_____Employer _____

PREFFERED METHOD OF CONTACT/PERMISSION TO CONTACT

May we contact you in the following ways? Please check all that apply.

- Text
- Call
- Email

By providing this information you agree to allow Home Town Dental to contact you in the method selected above and authorize us to leave messages regarding appointments or schedule changes. Please Initial: _____

How did you learn about our office?_____Our website_____Google____Ins. Provider Network___Friend/Family Referral Other_____

CLOSEST RELATIVE/ Emergency Contact

Spouse or closest relatives name(s) _____

Title Mr. Mrs. Ms. Miss. Dr. Other_____Relationship to patient _____

Address *(if different than patient address)* _____

Home Phone *(If different)* ( )_____-_____Cell phone ( )_____-_____Work phone ( )_____-_____

PRIOR DENTIST

Prior Dentist Name_____ Address, City, State_____

Last seen_____

Other dentists/dental specialists now being seen: Name_____City, State _____
Reason _____

PHYSICIAN

Patient's Physician_____City, State _____
Last seen_____Reason_____Next appointment Most recent physical exam _____

Other physicians/health care providers being seen now: Name_____ City, State _____
Reason_____
Name_____City, State_____
Reason

GENERAL INFORMATION

What concerns you about your teeth? _____

Why did you select our office?_____
Have you had any previous orthodontic treatment? Please describe._____
Have any other family members been treated in this office? Please name them. _____
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

CONSENT TO TREAT

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aidshe/she deems appropriate to make a thorough diagnosis of my dental needs.
I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated.
I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of Patient Date Relationship to patient

_____. _____. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address ***(if different than page 1)***_____City, State, Zip _____

Home phone ( )_____-_____Cell phone ( )_____-_____Email address(es) _____

Social Security #_____Employer _____

DENTAL INSURANCE

Primary policy holder's full name_____Birth date _____

Social Security #_____Relationship to patient _____

Address and phone (if not listed above) _____

Employer_____Address_____

Insurance company_____Group#_____ID#_____

Secondary policy holder's full name_____Birth date _____

Social Security #_____Relationship to patient _____

Address and phone (if not listed above) _____

Employer_____Address_____

Insurance company_____Group#_____ID#_____

OFFICE DENTAL INSURANCE NOTICE

To avoid misunderstanding regarding your dental insurance, we want to let you know that all professional services rendered are charged directly to the patient and that all patients are personally responsible for payment of fees.
We will prepare all necessary forms and/or reports to help you obtain your benefits from your insurance company as a courtesy.
We do not render our services on the basis that insurance companies will pay our fees, nor should you expect that they will.
We are required by law to collect all co-payments, deductibles and co-insurance payments and are not allowed to forgivecosts not covered by the insurance company. To do so would constitute as fraud.
Once statements are sent the balance is expected within 30 days to avoid interest or late fees. **Please Initial: _____**

MISSED APPOINTMENT NOTICE

A fee of $75.00 will be assessed to patients that do not give our office a minimum of 24 hours advanced notice of cancelation. We do acknowledge that emergencies and illnesses do happen and we will make exceptions accordingly. We are booked far in advance and frequently have waiting lists; those patients who would like to be seen are being deniedthe opportunity for a timely appointment. Without 24 hours' notice we are unable to offer your time to another.

I have read and understand this policy. **Please Initial: _____**

Name_____

31 Bailey Avenue , Ridgefield, CT 06877 , 203-431-3901

Request for Radiographs and Records

Dear Doctor _____

_____ (Name/Address/Phone number)

(Print Name)_____ has a new Patient Appointment in our office.

Prior to taking films this patient requested we contact your office regarding x-rays and pertinent dental records you may have on file.

Would you kindly forward to our office the following:

__X__ Bitewings taken less than 19 months ago

__X__ Full Mouth Series/ Panelipse taken less than 5 years ago. If digital please email in Dexis.

__X__ Date of last Prophy

Please include written records of history of care if you deem it necessary.

Thank you in advance for your time and consideration.

Sincerely,

Nicholas Ritzcovan, DDS

I hereby authorize the release of dental records, including x-rays to Home Town Dental, PC

(Sign)_____

Patient Signature

Email : nritzcovan2@gmail.com