

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 _____

PREFERRED 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 aids she/he 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 forgive costs 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 denied the 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 _____



HOMETOWN

FAMILY DENTISTRY

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

Nritzcovan2@gmail.com

Request for Radiographs and Records

Dear Doctor _____

Patient's 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 Propy

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

Please send in DEXIS if available, otherwise JPEG

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

Patient Signature

Email x-rays to : nritzcovan2@gmail.com