Town and Country
FAMILY DENTISTRY

Healthy Smiles. Healthy Family. Happy Life.

New Patient Registration

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

How did you learn of Town and Country Family Dentistry?
☐ Direct Mailing ☐ Friend/Relative ☐ Internet Search ☐ Insurance Plan ☐ Newspaper Ad ☐ Exterior Sign ☐ Facebook ☐ Twitter
☐ Other_____ If you were referred, whom may we thank for referring you?_____

Patient Information

Name _____ Nickname _____ Sex M F

SSN _____ Birth date _____ Cell Phone _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Email _____ Facebook _____ Twitter _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Separated

If student, name of school _____ FT / PT City _____ State _____ Zip

Patient or parent/guardian's employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____

Responsible Party

Name of person responsible for account _____ Relationship to Patient _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

Email _____ DOB _____ Work Phone _____

Are you currently a patient of this office? ☐ Yes ☐ No Drivers License # / State _____

Employer _____ SSN _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

DOB _____ SSN _____ Date Employed _____

Name of Employer _____ Address _____ Work Phone _____

City _____ State _____ Zip _____ Home Phone _____

Insurance _____ Group # _____ Policy/ID # _____

Insurance Address _____ City _____ State _____ Zip _____

Consent

I will answer all health questions on the Medical History From to the best of my knowledge_____ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date_____ Relationship to Patient_____

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Patient Medical History Form

Dental History

Why have you come in to see us today? (e.g.: pain, checkup, etc.)? _____

What is your biggest concern about your gums, teeth and/or mouth? _____

Previous Dentist & Location _____ Date of Last Cleaning _____

Do your gums bleed when flossing? ……..	☐ Yes ☐ No	Do you have frequent headaches? ……	☐ Yes ☐ No
Are your teeth sensitive to hot or cold? ……..	☐ Yes ☐ No	Do you clench or grind your teeth? ……..	☐ Yes ☐ No
Are your teeth sensitive to sweet or sour? ……..	☐ Yes ☐ No	Do you have bad breath or mouth odors? ……	☐ Yes ☐ No
Do you have loose teeth?	☐ Yes ☐ No	Do you bite your lips or cheeks frequently? ……	☐ Yes ☐ No
Do you feel pain in any of your teeth? ……...	☐ Yes ☐ No	Have you had difficult extractions in the past? ……	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No	Have you had prolonged bleeding after extractions?	☐ Yes ☐ No
Have you had any head, neck, or jaw injuries? ……..	☐ Yes ☐ No	Have you had any orthodontic treatment? ……...	☐ Yes ☐ No
Do you have dental anxiety? ……..	☐ Yes ☐ No	Do you wear dentures or partials? ……	☐ Yes ☐ No
Do you avoid brushing part of mouth due to pain? ……	☐ Yes ☐ No	If yes, date of placement: _____	
Have you ever experienced any of the following:		Have you ever received oral hygiene instructions	
Jaw clicking, popping or locking? ……	☐ Yes ☐ No	regarding the care of your teeth and/or gums? …….	☐ Yes ☐ No
Pain (jaw, joint, ear, side of face)? ……	☐ Yes ☐ No	Do you like your smile? ……...	☐ Yes ☐ No
Difficulty opening or closing jaw? …….....	☐ Yes ☐ No	Do you want your teeth straight? …..……...	☐ Yes ☐ No
Difficulty chewing ……..	☐ Yes ☐ No	Do you want whiter teeth? ……...	☐ Yes ☐ No

Medical History

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now?	☐ Yes ☐ No	Do you use tobacco?	☐ Yes ☐ No
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐ Yes ☐ No	Are you allergic to or have reactions to the following:	
Are you any medication(s), including non-prescription?	☐ Yes ☐ No	Local Anesthetics (e.g. Novocaine)	☐ Yes ☐ No
Have you ever taken Fen-Phen/Redux?	☐ Yes ☐ No	Sulfa Drugs	☐ Yes ☐ No
Have you ever taken any cancer medications?	☐ Yes ☐ No	Barbiturates	☐ Yes ☐ No
Have you taken Viagra, Cialis, or Levitra in the last 24 hours?	☐ Yes ☐ No	Penicillin or Antibiotics	☐ Yes ☐ No
Do you use alcohol?	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Do you use controlled substances?	☐ Yes ☐ No	Iodine	☐ Yes ☐ No
FOR WOMEN ONLY		Aspirin	☐ Yes ☐ No
Are you pregnant or think you may be pregnant?	☐ Yes ☐ No	Any Metals (e.g. nickel, mercury, etc.)	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No	Latex Rubber	☐ Yes ☐ No
Are you taking oral contraceptives?	☐ Yes ☐ No	Other (please list below)	☐ Yes ☐ No

Do you have or ever had any of the following? _____

High Blood Pressure	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Hay Fever Allergies	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	AIDS or HIV	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fainting/Seizures	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No

Medical History Cont.

Asthma	□ Yes □ No	Angina	□ Yes □ No	Glaucoma	□ Yes □ No
Low Blood Pressure	□ Yes □ No	Anemia	□ Yes □ No	Recent Weight Loss	□ Yes □ No
Epilepsy/Convulsions	□ Yes □ No	Emphysema	□ Yes □ No	Liver Disease	□ Yes □ No
Leukemia	□ Yes □ No	Cancer/Tumor	□ Yes □ No	Heart Trouble	□ Yes □ No
Kidney Disease	□ Yes □ No	Arthritis	□ Yes □ No	Respiratory Problems	□ Yes □ No
Thyroid Problems	□ Yes □ No	Joint Replacement/Implant	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No
Frequently Tired	□ Yes □ No	Liver Disease/Jaundice	□ Yes □ No	Hepatitis Type _____	□ Yes □ No
Bleeding Disorder	□ Yes □ No	Tuberculosis	□ Yes □ No	Psychiatric Treatment	□ Yes □ No
STD	□ Yes □ No	Stomach Trouble/Ulcer	□ Yes □ No	Other	□ Yes □ No

If you answered YES to any questions above, please explain:

Medications

Please list any medications that you are currently taking:

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

X _____ Date _____

Signature of patient (or parent /guardian if a minor)

Town and Country
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Patients with Commercial Health Insurance (Manage Care Plans)

This letter is to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, the manage care plans, like Preferred Provider Organizations (PPO), are not designed to pay for all dental care. They will only pay for dental care services that are determined medically needed and are considered "covered services." Covered services are defined in the managed care plan's group dental agreement. Most contracts have limits and/or various degrees of co-payment. If a managed care plan determines that a service is not medically necessary or not covered, as defined in group dental agreement, then the manage care plan will not pay for the service or pay for the lowest cost alternative option.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to delivering to our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

In certain cases, your doctor, based on his or her medical opinion, may request that the service, x-ray and/or test be performed that may not be considered a covered service as defined in your group dental agreement. Services a provider may request that may not be considered "covered services" may include, but not limited to:

- Periodic oral health maintenance examinations
- Certain screening or diagnostic tests
- Diagnostic x-rays or scans
- Oral biopsies
- Preventative treatments and services
- Other special procedures

However, it should be understood, **that the dental insurance contract is between the insurance company and the patient**, whom bears the ultimate financial responsibility.

Please take the time to review your contract thoroughly so we may best serve you. If you have a question or concern about a procedure that may not be covered by your insurance company, we encourage you to contact your insurance company directly. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Patient /Responsible Party Signature _____ Date _____

Town and Country
FAMILY DENTISTRY

FINANCIAL POLICY

Welcome:
Thank you for choosing us as your dental care provider. Dr. Mandefro and staff members are dedicated to serving your dental needs with the best professional advice, care and service obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. We are glad that you are here and we want to do our very best for you. We sincerely hope that your visit will be a pleasant and rewarding experience. If you have any questions during your dental exam today, please feel free to ask.

Payment:
We want to help remove financial barriers so you and your family can get the dental treatment you need. Many patients have some type of dental insurance, and we are able and pleased to assist you in maximizing your benefits. We also understand that not all of our dental families have dental insurance, and we want you to rest assured that we have payment options to meet most patient's needs.

We accept cash, checks, debit and most major credit cards. We offer two flexible financing options because we understand that monthly payments can help fit dental care into your budget. The first is through **Comprehensive Finance** (for those who qualify), with **Comprehensive Finance**, you can finance 100% of your treatment with no annual fees. **Comprehensive Finance** allows for flexible payments so you can find an option that works well for you and your family. The second is our in-house financing which offers convenient and flexible payment options, no interest, and no credit approval required.

Minors:
The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless a financial agreement has been arranged with the billing department prior to the appointment date along with a signed consent form.

Insurance:
We accept most insurance plans and are in-network with the majority of insurance plans. Insured patients will receive cost estimates broken down by insured and uninsured costs. For patients covered by insurance, we will accept assignment of benefits. This means that you sign the portion of your insurance that "assigns" payment to our office. Please note that estimates are based on information provided by your insurance and are not a guarantee of payment. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. As a courtesy, we file claim forms electronically, provide postage for special claims, and track claims for you.

In order for us to file your insurance we must have a copy of your current insurance card. If you do not have your insurance card at your first visit, full payment is due at the time of service. You are responsible for all co-pays and deductibles. We do not accept assignment of benefits for secondary insurance, however, we will provide a claim form to you, allowing you to file and be reimbursed by your secondary carrier.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your claim will be filed immediately, and the benefits expected are typically paid within 30 days. The filing of an insurance claim does not relieve you from the responsibility of your bill or the timely payment on your account. If the claim is not paid by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued for the unpaid portion.

We file claims to many different insurance companies, and it is virtually impossible for us to know your individual insurance policies. Please be aware that some, and perhaps all, of the services provided may be considered by your insurance

company to be NON-covered services and/ or might be subject to a deductible in addition to your co-pay. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.

We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, co-pays or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.

It is your responsibility to let us know of any insurance changes in a timely manner. Feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail.

Secondary Insurance:
We will gladly file to your secondary insurance. If you are interested, please ask for the secondary insurance policy when completing the new patient paperwork.

Late Payments:
If payments are late, declined, or if you request a change in date or amount not in accordance to this agreement, a $25 processing charge will incur for each instance. In the event that multiple payments are declined, treatment will cease until payment is current and future treatment is paid in full. If treatment has been completed, full payment will be due immediately.

Credits:
If after all payments have been received, the patient account has a negative balance, the credit card on file will be credited the exact amount within 60 days.

Collections:
If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

Missed Appointments:
Once an appointment has been made, that time is reserved specifically for you. If you need to cancel an appointment, we ask for at least a 48-hour notice. This allows us to offer the appointment to another patient. If you fail to keep your appointments without letting us know in advance, a $50.00 charge will be billed to your account.

Returned Check:
A returned check fee of $35 will be added to your account for any returned check. Before we accept another payment by check, the $35 fee plus full payment for the check that did not clear must be paid in cash, or by Visa, MasterCard, AMEX, or Discover.

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of the financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Town and Country Family Dental Care.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature of Patient or Responsible Party: _____ Date: _____

Town and Country
FAMILY DENTISTRY

Important Information for Our Patients

Terms of Payment

The following is a guide to the terms of payment we accept. We are committed to working with you to match a payment plan to your needs; therefore we offer different options to our patients, which allows for payment to be convenient and flexible. We are available to answer any questions you may have.

Dental Insurance

We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please ***be sure to provide us with your dental insurance card.*** Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

We do not accept assignment of benefits for secondary insurance, however, we will provide a claim form to you, allowing you to file and be reimbursed by your secondary carrier.

Payment Options

- A pre-authorized 0% interest monthly payment plan on your credit card (requires no credit check)
- A convenient low payment plan through an outside financial institution (requires credit check)
- We accept Visa, MasterCard, AMX, money order, cash, or personal check.

Appointments

In order to allow the best possible care for our patients we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a **48-hour notice is required** or you may be charged a $50 cancellation fee.

Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company, therefore I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Dr. Azaryas Mandefro
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Notice of Privacy Practices for the office of
Town and Country Family Dentistry
Dr. Azaryas Mandefro, DMD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities.

This practice may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. We may also use information about your demographic and dates of treatment in order to contact you for our fundraising activities. If you do not want the information about treatment alternatives, other health related benefits, services, or fundraising, you may notify our office and you will receive no further information

Authorized Disclosures- For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence
This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Privacy standard. This practice requires that all requests for the various rights be made in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request.

Right of an individual to request restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations.

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at this phone number at the end of this document.

Amendment of protected health information
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Copy of this notice
You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain.

Complaints

If at any time you feel we have violated your privacy rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office Of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.