**DENTAL ASSOCIATES OF ROCKVILLE, LLC**

50 Hale Street
Rockville, Connecticut 06066
(860) 872-0794
dardentist@sbcglobal.net

Welcome to Dental Associates of Rockville!

We thank you for making us your choice and joining with us in caring for your dental health. By becoming our patient, you have created a partnership which we hope will last through the years.

Since 1959, our partnership has been prevention orientated and dedicated to your health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long term dental health.

Our office hours are patient orientated. We are here as early as 7am, late as 7pm, and even on Saturdays. Because communication is important, we will advise you of treatment needs and expenses in advance, even assist with your insurance filing. We are here to serve you so please, do not hesitate to contact us regarding any matter.

We welcome new patients and appreciate any referrals we might earn. Our practice again welcomes you and looks forward to a long and healthy partnership with you, your family, and friends.

Best Regards,

Dental Associates of Rockville
David Janton DMD, Mang Shu DMD, and Sydney Spal DDS
Shannon, Sarah, Theresa, Carole, Janelle, Chelsea and Brianna

# Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

## Patient and Family Information

Child's Name _____ Birthdate _____ ☐Male ☐Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

## Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

## Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type _____ ☐ Tuberculosis

☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other _____

☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever _____

☐ Cancer ☐ Heart Murmur ☐ Tonsillitis _____

## Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____


## Additional Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

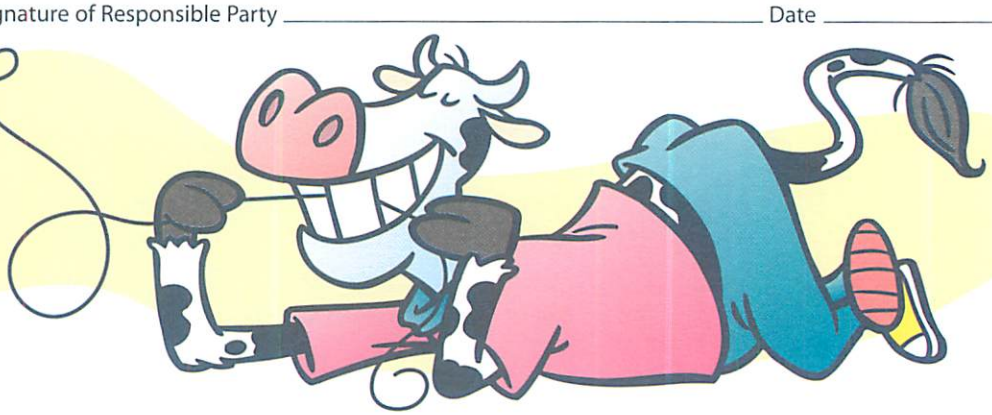
Subscriber I.D. # _____ Group # _____

## Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Dental Associates of Rockville, LLC
50 Hale Street
Rockville, CT 06066

## OFFICE AND FINANCIAL POLICY:

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, and Visa. Returned checks and account balances older than 90 days may be subject to additional collection fees. All collection costs, court costs, and attorney's fees will be your responsibility.

**Charges may also be made for broken appointments. We must have 48 hours (2 days) notice of cancellation of appointments. If we do not have the required 48-hour cancellation notice, you may be charged a "No Show" fee of $50-150 (depending on service type). Patients that miss two or more appointments without calling to cancel/change their appointment will be discharged/dismissed from our practice. We currently have a waiting list of patients for appointments. If you cannot make your appointment, please notify us so we can give someone else that appointment time. Frequent missed appointments have a huge impact on our ability to see and treat our patients and cannot be overlooked.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts.
We must emphasize that as dental care providers, our relationship is with you, not your insurance company.
While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered, as well as any costs incurred for collection.

_____ _____

Patient's signature Date

## AUTHORIZATION TO PAY BENEFITS AND TO RELEASE INFORMATION

I hereby authorize payment directly to the above name dentist of the dental benefits otherwise payable to me. I hereby authorize the above-named dentist to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

_____ _____

Patient's signature Date

# Dental Associates of Rockville, LLC

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

**Signature**_____**Date**_____

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**PATIENT GIVING CONSENT:**

**Name**_____

**Address**_____

**Telephone**_____**Social Security #**_____

**Purpose of consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Right to Revoke:** You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Signature:**

I,_____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature**_____**Date**_____

**Spouse/parent/Guardian**_____**Date:**_____

# Notice of privacy practices

Important: this notice describes your privacy rights as a patient of Dental Associates of Rockville, LLC and how your medical information may be used and disclosed. Please review this notice carefully and let your service provider know if you have any questions.

## Our Legal Duty

The terms of this notice of privacy practices applies to all services performed and are effective April 1, 2003. This organization and its employees will share individual patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This agency is required by law to maintain the privacy practices with respect to your individual health information. We reserve the right to change the terms of this notice of privacy practices as necessary.

## Uses and Disclosures of Health Information

We may use or disclose health information about you for:

### Treatment, Payment and Health Care Operations:

Except as otherwise provided, or with your signed consent, this agency will use your individual health information as necessary for purposes of your treatment, payment and as necessary for our health care operations which include clinical supervision, clinical improvement, professional peer review, business management, and accreditation and licensing, as permitted by law.

### Family and Friends:

AUTHORIZATION IS NECESSARY TO RELEASE YOUR HEALTH INFORMATION

### Business Associates

At times it may be necessary for us to provide your individual health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc.

### Appointments and services

This agency may contact you to provide appointment reminders or information about your treatment alternatives or other health-related benefits and services that may be of interest to you.

## Your rights

### 1. Access to individual health information

You have the right to inspect the record of your individual health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. We will charge you a fee of 25 cents per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information of you request such a summary.

### 2. Amendments to individual health information

You have the right to request in writing that individual health information that we maintain about you be amended or corrected.

### 3. Accounting for disclosures of individual health information

You have the right to receive an accounting of certain disclosures made by us of your individual health information after April 14, 2003.

### 4. Restrictions on use and disclosure of individual health information

You have the right to request certain restrictions on certain of our uses and disclosures of your individual health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests.

### 5. Complaints

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer at this practice. You may also file a complaint with the Secretary of the Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.