Dr. Marshall Baldassarre, D.M.D 404 Riverway Place, Blg #4 Bedford, NH 03110 603-624-8042

Patient Information

Date: ___________________

Patient Name: ____ Date of Birth: _______________

Patient Address: ____ State:______ Zip code:_______________

Patient Home Phone Number: _____-______-________ Patient Cell Phone Number: _____-_____-_______

Patient Social Security Number: ______-______-_______ Sex: ____ Email: ____

Are you a full time Student? Yes: ____ No: ____ Marital Status: ___________________________

Employer: ____

Street Address: ____ State: _____ Zip Code: __________

Insurance Information:

1. ***Dental Insurance Carrier:*** ____ Phone Number: ____-_______-_______

Address: ____ State: _____ Zip Code: ________

Patient ID#:____ Group #:__________________________

Subscriber Name: ____ Subscriber Date of Birth: ________________

2. ***Medical Insurance Carrier:*** ____ Phone Number: _____-_______-_______

Address: ____ State: _____ Zip Code: ________

Patient ID#:____ Group #:__________________________

Subscriber Name: ____ Subscriber Date of Birth: ________________

3. ***Additional Insurance Carrier:*** ____ Phone Number: _____-_______-_______

Address: ____ State: _____ Zip Code: ________

Patient ID#:____ Group #:__________________________

Guarantor Information:

Party Responsible for Patients Bill if other than self:____

Relation to patient: ____________________________ Date of Birth: ____-____-_____ Phone Number: _____-_____-_______.

Street Address: ____ Town: _____________________ State: ________ Zip Code: ________

Patient Name: ____ **Date of Birth**: _________________________ Age:________

Has the patient ever had any of the following medical conditions?

	Yes	No
Rheumatic Fever:	______	______
Heart Murmur:	______	______
Heart Trouble:	______	______
Heart Valve Replacement:	______	______
High Blood pressure:	______	______
Coronary Bypass:	______	______
Bleeding Problems:	______	______
Immune Deficiency:	______	______
Hip or Knee Replacement:	______	______
Epilepsy/ Seizures:	______	______
Kidney Disease:	______	______
Diabetes:	______	______
Hepatitis or Liver Disease:	______	______
Arthritis:	______	______
TMJ Problems or Pain:	______	______

	Yes	No
Sinus or Nasal Problems:	_______	_______
Lung Trouble:	_______	_______
Asthma:	_______	_______
Tuberculosis:	_______	_______
Fainting spells:	_______	_______
Anemia:	_______	_______

Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for Osteoporosis, or Chemotherapy for multiple myeloma, ect.) ____________________________ Y N

Do you have or ever had cancer ____________________ Y N

Radiation (X-Ray) treatment for Cancer? _____________ Y N

General Anesthesia ________________________ When?________________ What ?__________________

Have you ever been Hospitalized? When? ________________ Why?____

Have you had any serious illness or injuries? ____

____

Have you ever been under a physician's care within the past five years? Yes__________ No____________

If so why? ____

Do you have any other disease, condition or problem not listed that you think the doctor should know about? Yes______ No______

If so what?____

	Yes	No
Are you in good health?:	Yes ____	No____
Are you taking birth control pills?:	Yes ____	No____
Are you pregnant?:	Yes ____	No____
Have you ever taken steroids or prednisone?:	Yes ____	No____
Do you smoke/chew tobacco?:	Yes ____	No____
Do you have a cold or Bronchitis?:	Yes ____	No____
Are you allergic to Penicillin?:	Yes ____	No ____
Other allergies?:	Yes ____	No ____

List Medications:

____
____
____
____
____
____
____
____

Note: Patients taking birth control pills who are prescribed antibiotics should use another method of birth control for the remainder of the cycle. **Initial:** _________

Dentist________________________ City__________________ State________ Phone #____________________________

Physician_______________________City__________________State________Phone #_____________________________

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with the doctor.

__________________ ____

Date Signature

BEDFORD
ORAL SURGERY

OFFICE FINANCIAL POLICY

Please read this Office Policy sheet carefully. If there is anything you do not understand about our policy for payment and assistance with insurance processing please ask.

Please contact your Human Resources department if you have any questions or complaints about benefits provided by your insurance. They need to know.

Obtaining reliable financial information from insurance companies regarding oral surgery procedures is difficult. Contract allowances have many conditions for eligibility established by the insurance carrier not based on the need for the service.
These conditions for eligibility change and we are not apprised of the changes.

Treatment Fee and Payment:

- ✓ Payment is expected at the time of treatment.
- ✓ Financial arrangements can be made in advance of your appointments.
- ✓ Estimated payments are due at the time of your appointment.
- ✓ Pretreatment estimates can be submitted to your insurance company so that they can provide you with financial information regarding the amount they will or will not pay towards the above treatment. **Any quotes are ESTIMATES only**. We will do our best to help you with insurance information from your insurance company.
- ✓ An insurance handling fee of $25.00 may be charged to your account if additional filling is required for coordination of benefits.
- ☐ I understand that ESTIMATES of insurance benefits for services performed both verbal and written are only ESTIMATES.
- ☐ I understand that this office attempts to obtain information about YOUR BENEFITS as a courtesy to you.
- ☐ **I understand that any information this office provides you regarding benefits coverage is not a guarantee in any respect that the insurance company will pay this amount.**
- ☐ **I will not hold this office responsible for benefit information obtained on MY behalf. The information may not be accurate. Ultimately this information is your responsibility, we are only assisting you.**

- ☐ All balances are due in full 90 days after treatment *regardless of insurances intent to pay.*

- ☐ **I understand that my dental insurance carrier and or medical insurance carrier may pay less than the actual fee and or estimate for services provided in writing or verbally. ALL estimates are nonbonding. I agree to be responsible for payment of all services rendered on my behalf of my dependents.**

Authorization and Release:

______ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or other health practitioners.
______ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
______ I authorize release of payment and claims information by my insurance company to Dr. Baldassarre. Patient or

Guarantor Signature: ______________________________ Date: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

I give permission for Dr. Baldassarre's office to e-mail treatment information to my healthcare providers. The e-mail communications are sent SECURE/ENCRYPTED.

If you would like us to share your treatment information with any other person, please list their name(s) (e.g. spouse, parent) ____

Please Print Name/Signature: Date:

____ ___________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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