O'Dwyer Family Dentistry

15 West Middle Turnpike, Manchester, CT 06040 (860)643-6992 fx(860)645-1882

Our Mission

In our dental practice, we strive to serve the needs of you, our valued patients, to the best of our ability. We aim to provide the highest quality dental care in a relaxed and comfortable environment. We understand you have a choice in dental care, and we thank you for choosing our office. Please read the following patient agreements and sign at the bottom stating that you have read and understand each agreement.

Patient Agreements

Confirmation
This office strives to be considerate of our patient's time. We do not double book appointments and we do our best to stay on time. ALL appointments MUST be confirmed before 3:00PM the day before your appointment. You may reach us during office hours or leave a voicemail message after hours to confirm. **Unconfirmed appointments will be cancelled.**

Arrival
We understand that your time is limited and valuable. We will make every effort to see you at your appointed time. For this reason, we ask you to be ready for treatment at your appointed time. If you are more than 10 minutes late, we may need to reschedule your appointment.

Cancellations and Rescheduling
We understand that it may become necessary to change an appointment. As a courtesy to our staff and to our other patients, we ask that you let us know immediately if you cannot keep your appointment. Appointments cancelled or rescheduled fewer than 24 hours before the appointment time may be assessed a $75.00 cancellation fee.

Dental Insurance
While we assist you in obtaining benefit information, we are not privileged with the detailed provisions of your particular plan. All estimates provided in our office are based on general benefit information. Questions regarding your specific dental benefits should be directed to your insurance company. You are ultimately responsible for all charges incurred in our office. You will receive a statement from our office for any unpaid balances.

Financial Information
Payment by the patient is expected at the time services are provided unless other arrangements have been made with our office in advance. As a service to our patients, we are pleased to offer the CareCredit card, the nation's leading patient payment program, which you can use to finance 100% of your dental care interest free for up to 18 months with no upfront costs, no annual fees, and no pre-payment penalties. O'Dwyer Family Dentistry is not responsible for seeking payment from third parties.

_____ _____ _____

Patient Signature Printed Name Date

Dr. O'Dwyer's Office

1 Patient Information

Date:_____

Name:_____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child Date of Birth:_____ Age:_____ S. S. #:_____

Address:_____ City:_____ State:_____ Zip_____

Home Phone: (___)_____ Work: (___)_____ ext._____ Cell: (___)_____

How did you hear of our office?_____

Employer:_____ Occupation_____

Spouse Information:

Name:_____ Date of Birth: _____ S.S. #:_____

Employer:_____ Occupation_____

2 If under the age of 18, who will be responsible for balances?

[ ] Same as Above Name:_____ Date of Birth:_____ Relation:_____

Home Phone: (___)_____ Work: (___)_____ ext._____ Cell: (___)_____

3 Dental Insurance Information

Primary Insurance:

Insurance Comp. Name:_____ Phone:(___)_____ Group#_____

Insured's Name:_____ Insured's Date of Birth: _____ Relation:_____

Insured's S.S.#:_____ ID#:_____ Insured's Employer:_____

Secondary Insurance:

Insurance Comp. Name:_____ Phone:(___)_____ Group#_____

Insured's Name:_____ Insured's Date of Birth: _____ Relation:_____

Insured's S.S.#:_____ ID#:_____ Insured's Employer:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company and assign directly to Dr. O'Dwyer all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

4 Medications and Allergies

Please list the medications you are currently taking:

_____

_____

Please list any allergies you have:

_____

_____

5 Medical History Information

Name of Physician:_____ Phone: (____)_____

Do you have or have ever had any of the following? Please check all that apply:

[ ] Allergies/Hay Fever	[ ] Fainting or Dizziness	[ ] Mental Disorders
[ ] Anemia	[ ] Fever Blisters/Cold Sores	[ ] Mitral Valve Prolapse*
[ ] Angina	[ ] Frequent Cough	[ ] Osteoporosis
[ ] Arthritis	[ ] Glaucoma	[ ] Radiation Treatment
[ ] Artificial Joints*	[ ] Heart Disorder (Congenital)*	[ ] Respiratory Problems
[ ] Artificial Heart Valves*	[ ] Heart Murmur*	[ ] Rheumatic Fever
[ ] Asthma	[ ] Heart Pace Maker*	[ ] Sinus Problems
[ ] Breathing Problems	[ ] Heart Surgery*	[ ] Stroke
[ ] Cancer	[ ] Hepatitis	[ ] Surgical Shunt*
Type: _____	[ ] High Blood Pressure	[ ] Thyroid Problems
[ ] Chemical Dependency	[ ] HIV*/AIDS	[ ] Tuberculosis
[ ] Chemotherapy	[ ] Kidney Problems	[ ] Ulcers
[ ] Diabetes	[ ] Liver Problems	[ ] Venereal Disease
[ ] Epilepsy or Seizures	[ ] Low Blood Pressure	[ ] Yellow Jaundice

* This condition may require antibiotic premeditation for certain dental procedures.

Do you have any heath problems that were not listed above or need further clarification? [ ] Yes [ ] No

If yes, please explain:_____

Women: (Please Check) [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at my next appointment.

_____ _____

Signature of patient or guardian Date

6 Dental History

Reason for today's visit:_____

Former Dentist:_____ Phone:(____)_____ City/State_____

Date of last dental visit (approx)_____ Date of last dental x-rays (approx)_____

Do you have or have you ever had any of the following? Please check those that apply:

[ ] Bad Breath	[ ] Fingernail Biting	[ ] Mouth pain when brushing
[ ] Bleeding Gums	[ ] Food collection between teeth	[ ] Orthodontic treatment
[ ] Blisters on lips/mouth	[ ] Grinding teeth	[ ] Pain around ear
[ ] Burning sensation on tongue	[ ] Gums swollen or tender	[ ] Periodontal treatment
[ ] Chew on one side of the mouth	[ ] Jaw pain or tiredness	[ ] Sensitivity to cold
[ ] Cigarette, or cigar smoking	[ ] Lip or cheek biting	[ ] Sensitivity to heat
[ ] Clicking or popping jaw	[ ] Lose teeth or broken fillings	[ ] Sensitivity when biting
[ ] Dry mouth	[ ] Mouth breathing	[ ] Sores/growths in mouth

How often do you brush?_____ How often to you floss?_____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

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

Please Sign:_____ Date:_____

For Office Use Only:
We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
[ ] Individual refused to sign
[ ] Communications barriers prohibited obtaining the acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other (Please Specify)_____