Welcome! Thank you for choosing New Hampshire Smile Company and for trusting Dr. Darcy Neveu for your dental healthcare needs. We promise to do our best to provide you with the finest care available. Our team is committed to making your treatment both a pleasant and successful experience. If you have any questions, need assistance completing these forms, or there is anything we can do to make your visit with us and your experience here more comfortable, please let us know.

PATIENT INFORMATION:

Name: ______________________________ Date: ____________ DOB: ______________

Please circle: Married Single Widowed Gender: Male Female

Email: ______________________________ Social Security #: ______________________

Phone: Home: (_______)__________ Cell: (_______)__________ Work: (_______)__________

Preferred method of contact (please circle): Home Cell Work Text Email

Physical address: ____
Street Apt# City State Zip Code

Mailing address:____
Street Apt# City State Zip Code

HOW DID YOU HEAR ABOUT US?

Please circle: Friend Relative Internet Search Sign Insurance Company Other

Name of referral source (which friend, search engine, relative, etc): ____________________

INSURANCE INFORMATION

PRIMARY: Subscriber name: _________________________ Subscriber DOB: ______________

ID#: __________________ Group #: __________________ Plan name: __________________

Mailing address: ________________________________ Phone #: __________________

Employer name: _________________________ Occupation: _________________________

SECONDARY: Subscriber name: _______________________ Subscriber DOB: ______________

ID#: __________________ Group #: __________________ Plan name: __________________

Mailing address: ________________________________ Phone #: __________________

Employer name: _________________________ Occupation: _________________________

RESPONSIBLE PARTY:

Name of person responsible for account: ______________________________ Relationship to patient: __________

Mailing address:____

Street Apt# City State Zip Code

Phone: Home: (_______)_______________ Cell: (_______)_______________ Work: (_______)_______________

Is this person currently a patient in our office? Yes No

REGARDING SCHEDULED APPOINTMENTS/BROKEN APPOINTMENT POLICY: We make every effort to be on time for our patient's appointments, and ask that you extend the same courtesy to us. When you are late for an appointment, other patients may be kept waiting, and we are not able to serve you with the care that you deserve. Please be on time for each appointment. Allow a little extra time for parking so that you arrive on time for your appointment start. If you are more than 10 minutes late, or half-way into the allotted time for your scheduled appointment, it will be considered a broken appointment and we will need to reschedule you. If you must change your appointment, call us at least 48 hours in advance. A missed appointment time is time that could be used to benefit another patient. If you miss an appointment or cancel with less than 48 hours' notice, a missed appointment fee of $50 or 10% (whichever is greater) will be charged to your account.

REGARDING FINANCIAL ARRANGEMENTS: Payment for services rendered is considered part of your treatment and is due at the time of service, unless financial arrangements are made prior to treatment. This policy is instrumental in eliminating costly administrative expenses associated with billing procedures. Any balance unpaid for more than 60 days will be subject to an interest charge, and any balance left unpaid for more than 90 days will be sent to collections.

WE ACCEPT THE FOLLOWING METHODS OF PAYMENT:
Cash, Check, Visa, Mastercard, Discover, American Express, CareCredit, Lending Point

REGARDING INSURANCE: We are happy to help file your insurance claim for you. This is a service that we provide for our patients to help eliminate some of the often confusing paperwork associated with processing claim forms. **PLEASE REMEMBER THAT YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** Our office is not party to the contract. We will do our best to estimate your portion of the fee and help you to utilize your insurance benefit. However, you will ultimately be responsible for any amount unpaid by your insurance company. Please be aware that some treatments provided may not be considered customary by your insurance carrier, and may be labeled "non-covered" or "plan exclusion" under your particular plan according to each individual's policy.

Thank you for your understanding of our financial policy. Please let us know if you have any questions. We reserve the right to modify these policies at any time without further notice.

CONSENT FOR SERVICES

I authorize Dr. Darcy Neveu, and all team members who may be designated, to perform dental treatment and other related procedures or forms of treatment, including appropriate radiographs, anesthesia, or analgesia they may deem necessary. I understand that the expected results of such treatment cannot always be guaranteed. To the best of my knowledge, this paperwork has been accurately answered. I will bring all future changes in my medical history to the attention of my doctor. I understand that providing incorrect or incomplete information can be dangerous to my health. I grant my permission to Dr. Neveu or her assignee to telephone me at my home or work, to send texts or emails, to discuss matters related to this form or my oral health. I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension of the proposed procedure or a change from what was previously noted. If that occurs, I authorize Dr. Darcy Neveu and all team members of New Hampshire Smile Company to perform such procedures as necessary and desirable in the secerice of professional judgement, and I will be responsible for any associated fees. I authorize my insurance benefits to be paid directly to New Hampshire Smile Company. **I UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS OF TREATMENT, THE BROKEN APPOINTMENT POLICY, AND THE OFFICE FINANCIAL POLICIES, AND WILL BE RESPONSIBLE FOR PAYMENT OF MY TREATMENT.** I authorize New Hampshire Smile Company to release any and all photographs taken of the previously named patient for teaching purposes, for educational journals or posts, and for marketing purposes.

SIGNATURE: ____ DATE: ________________________________

MEDICAL HISTORY

Patient name: ______________________________ DOB: ______________ Date: ______________

Emergency Contact (name and phone number): ______________________________

Name of physician: ______________________ Physician's phone number: ______________________

Date of last visit to physician: ______________________ Rate your general health: POOR FAIR GOOD

1: Please list ALL medical conditions that you have been diagnosed with by a physician: ______________________

____

2: Please list ALL medications, vitamins, herbal or dietary supplements that you are currently taking: ______________

____

3: Do you, or have you previously, taken any of the following medications: (please circle)

Coumadin/Warfarin Plavix Fen-phen/Redux/Pondimin Fosamax/Boniva, Actonel, Zometa, Aredia

4: (Women) Are you currently pregnant, trying to get pregnant, or are you nursing? .... YES NO

5: Do you take oral contraceptives? .... YES NO

6: Are you allergic/sensitive to (please circle): CODEINE PENICILLIN LOCAL ANESTHETIC LATEX DYES

Please list any other allergies you are aware of: ______________________________

7: Do you smoke or chew tobacco? .... YES NO

If yes, which one, how much, and for how long? ______________________________

8: Do you have diabetes? .... YES NO

If yes, please indicate: TYPE 1 TYPE 2 Last HbA1c date and level: ______________________

9: Do you have, or have you ever had (please circle):

AIDS/HIV Positive	Convulsions	Heart Murmur	Recent Weight Loss
Alcohol or Drug Dependency	Cortico-Steroid Treatment	Heart Pacemaker	Recreational Drug Use
Alzheimer's Disease	Depression	Heart Problems	Renal Dialysis
Anaphylaxis	Diabetes	Heart Surgery	Respiratory Problems
Anemia/Bleeding Disorder	Dizziness/Fainting	Hemophilia	Rheumatic Fever
Angina	Drug Addiction	Hepatitis (Type A, B or C)	Rheumatism
Arthritis/Gout	Dry Mouth/Dry Eyes	High Blood Pressure	STD
Artificial Heart Graft, Valve or Stent	Easily Winded	High Cholesterol	Scarlet Fever
Artificial Joints	Emphysema	Hypoglycemia	Shingles
Asthma	Epilepsy/Seizures	Irregular Heartbeat	Sickle Cell Disease
Autoimmune Disease	Excessive Bleeding	Jaundice	Sinus Problems
Blood Disease	Excessive Thirst	Kidney Disease/Dialysis	Sleep Apnea
Blood Transfusion	Frequent Cough	Leukemia	Spina Bifida
Breathing Problems	Frequent Diarrhea	Liver Disease	Stroke
Bruise Easily	Frequent Headaches	Low Blood Pressure	Swelling of Limbs
COPD	Gastrointestinal Disease	Lung Disease	Thyroid/Parathyroid Problems
Cancer	Genital Herpes/Herpes	Mitral Valve Prolapse	Tonsillitis
Chemotherapy/Radiation	Glaucoma	Mood Disorder/Emotional Problems	Tuberculosis
Chest Pains	Hay Fever, Hives, Skin Rash	Osteoporosis	Tumors or Growths
Cold Sores	Hearing Impared	Pain in Jaw Joints	Ulcers/GERD
Congenital Heart Defects	Heart Attack	Psychiatric Care	Venereal Disease

PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS AT FUTURE APPOINTMENTS

Patient's Signature: ______________________ Doctor's Signature: ______________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's name: ____ DOB: ____________________

Address: ____ Phone: ____________________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to use and disclosure of you or your child's protected health information to carry out treatment, payment activities, and healthcare information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of you or your child's protected health information, and of other important matters about you or your child's protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions to the notice at any time by contacting NH Smile Company at our mailing address: 707 Milford Rd, Unit 27, Merrimack NH, 03054 or by phone: 603-886-1976.

Right to Revoke: You will 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.

PRIVACY AUTHORIZATION

I give consent for Dr. Neveu and team members to speak with the following person(s) regarding my dental care:

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

SIGNATURE FOR CONSENT:

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

Patient/Parent's name: ____

Patient/Parent's signature: ________________________________ Date: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

TAKE OUR SMILE ASSESSMENT TO SEE IF YOU MIGHT BE A CANDIDATE FOR AN ENHANCED SMILE!

	YES	NO
Are you comfortable showing your teeth when you smile?	◯	◯
Are you happy with the appearance of your smile?	◯	◯
Do you have unsightly crowns or fillings?	◯	◯
Are your teeth sensitive to hot or cold?	◯	◯
Do you feel that your teeth are too short or too long?	◯	◯
Do you like the color of your teeth?	◯	◯
Do you have a history of orthodontic care?	◯	◯
Are you familiar with the benefits of Invisalign?	◯	◯
Are you interested in replacing missing teeth?	◯	◯
Are you familiar with the benefits of dental implants?	◯	◯
Are your gums receding?	◯	◯

What, if anything, is holding you back from your perfect smile?

Fear ◯

Time ◯

Cost ◯

Other: ______________________________

NH Smile Co. ▪ 707 Milford Road, Unit 27 Merrimack, NH 03054 ▪ 603-886-1976