HANNA&MAZER
DENTAL GROUP

Date of Initial Visit_____

PATIENT INFORMATION

Patient First Name _____ M.I. ___ Patient Last Name_____

Address _____ City, State, Zip _____

Email _____ Date of Birth _____ Sex: □ M □ F

SS # _____ Home (_____)_____ Cell (_____)_____

Emergency Contact _____ Relationship to Patient _____

Contact's Home (_____)_____ Contact's Cell (_____)_____

Whom may we thank for referring you to our office? _____

PATIENT OCCUPATIONAL STATUS

Select One: □ Employed □ Unemployed

□ Student □ Retired □ Other

Employer/School _____

Job Title _____

Address _____

City, State, Zip _____

Work Phone (_____)_____

PATIENT MARITAL STATUS

Select One: □ Married □ Single □ Child/Minor

□ Other_____

Spouse's Name _____

Spouse's Date of Birth _____

Spouse's SS # _____

Spouse's Employer _____

Spouse's Job Title _____

DENTAL INSURANCE

Select One: □ Yes, see below □ No, self pay

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's SS # _____ Relationship to Patient _____

Insurance Company _____ Group # _____ ID # _____

Is this patient covered by additional dental insurance? □ Yes □ No

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to **The Hanna & Mazer Dental Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I can request in writing to terminate this consent at any time, if I so choose.

_____

Patient, Parent or Guardian Name (Please Print)

_____

Patient, Parent or Guardian Signature Date

61 Fourth Street, Stamford, CT 06905
P: (203) 348-3756 | F: (203) 348-8675
info@hannaandmazer.com | www.hannaandmazer.com

HANNA&MAZER DENTAL GROUP

DENTAL HISTORY

What is the reason for today's visit? _____

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

Select all conditions that apply to you:

Bad Breath	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No
Blisters on lips/mouth	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Chewing on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Cigarette, pipe or cigar smoking	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Food collection between teeth	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No	Sores or growths in the mouth	☐ Yes ☐ No

HEALTH HISTORY

General Physician's Name _____ Date of Last Visit _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name/City _____ Phone (____)_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No Do you take birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

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MEDICAL CONDITIONS

Select all conditions that apply to you:

AIDS/HIV	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
		Pacemaker	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Tumor/growth on head or neck	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Hepatitis Type _____	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No

ALLERGIES

Select all allergies that apply to you:

- ☐ Aspirin
- ☐ Augmentin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Food Related _____
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Vicodin
- ☐ Other _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of the Hanna and Mazer Dental
(First Name)
Group's Privacy Policy AND/OR read the copy that was provided to me upon request from the

Hanna & Mazer Dental Group front desk.

_____

Patient Full Name (Please Print)

_____

Patient, Parent or Guardian 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other: _____

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FINANCIAL POLICY

Our primary mission is to deliver the best and most comprehensive dental care available to every patient. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible, by offering several payment options/methods.
Our office requires payment or a financial arrangement put into place prior to the completion of your treatment. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment[3]. Our office can estimate your insurance benefit; however, this is not a guarantee and you are ultimately responsible for your balance.

PAYMENT OPTIONS:

- Cash or Check
    - We offer a 5% discount to patients who pay for their ($1,000 or more) treatment plans with cash or check prior to the completion of care.
- Credit Card (Visa, Master Card, or American Express)
- NO INTEREST[1] Payment Plans[2] from **CareCredit**
    - Allow you to pay overtime with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] available
    - No annual fees or pre-payment penalties

Please Note:

- All overdue balances are subject to interest charges of 1.5% per month. Any unpaid balances over 90 days that do not have a financial arrangement in place, may be turned over to our collection agency or small claims court. These balances are subject to collection fees and court/attorney costs.
- A fee of $75 is charged when a patient misses or cancels more than 1 time in one calendar year without 48 hour notice.
- Fee for a returned check is $35 that will be billed to that patient's account.

If you have any questions, please do not hesitate to ask. We are here to help you get the very best dental care you want and deserve.

Patient Name (Please Print)

Patient, Parent or Guardian Signature **Date**

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2]Subject to credit approval.
[3]If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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RECORDS REQUEST

Previous Dental Office _____

Previous Dentist's Name _____

Street Address _____

City _____ State _____

Phone Number _____ Fax Number _____

PLEASE RELEASE RECORDS TO OUR OFFICE FOR THE FOLLOWING PATIENT:

Patient's Name _____ Date of Birth _____

Street Address _____

City _____ State _____

Additional Family Members _____

Please e-mail copies of any X-rays to: info@hannaandmazer.com

Date of Last Prophylaxis and Oral Exam ____ /____ /_____

Date of Last X-rays (Bitewings) ____ /____ /_____ (FMX or Panorex) ____ /____ /_____

_____

Patient, Parent or Guardian Signature **Date**

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Email and Text Messaging Form

Our office provides our patients with the option to participate in our online patient communication system. Some of the system features allow you the ability to:

- Request Appointments via Email
- Confirm Appointments via Email
- Receive a Text Message Appointment Reminder
- Reply via Text Message
- Submit a Patient Satisfaction Survey
- Refer Your Friends and Family Online

You may opt-out of the communications at any time by clicking the unsubscribe link located in the footer of each email, or by replying to a text message with "STOP". Standard text messaging rates may apply depending on your cell phone plan.

Please Verify Your Contact Information

Name: _____

Cell Phone Number: _____

Email Address: _____

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPPA. These parties are required by law to sign a contract with agreeing to protect the confidentially of your PHI. Your PHI may be disclosed to an affiliate that performs services for Dr. Hanna and Dr. Mazer in the administration of your benefits Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mails or other communications without the users permission, and they do not send spam. Please sign below to indicate that you agree to allow us to use this information in providing your services.

_____
Signature

_____
Date

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