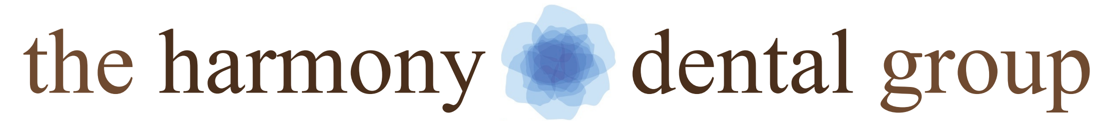

PatientName:________________________________ Date:________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address:______________________________ ______________ ________ ________
Street City State Zip

Social Security #:__________________________ Birth Date:____________________

HomePhone__________________WorkPhone______________Cellphone______________

Email____________________________Text Messages ☐ Yes ☐ No Carrier:____________

Who should we contact in the case of an Emergency? Name ______________Phone______________

Referral Information

How were you referred to us: ☐ Family member____________ ☐ Friend ____________ ☐ Google search

☐ Direct mail ☐ Other __________________________

Dental Insurance

Insurance Name: ____________ Employer Name: __________Employee Name:______________

Work Address:______________________________ ______________ ________ ________
Street City state zip

Birth Date: __________Social Security/Insurance ID #______________ Group # ____________

Health Information

Physician________________Address______________________phone______________

Are you in good health? ________ If no, explain__________________________________

Do you have an existing illness? ______ If yes, explain______________________________

Have you ever had a surgery? ________If yes, explain_______________________________

Do you bleed excessively when cut?________ Do you smoke? _______ if yes, how much? ____________

Are you taking any Medication?________ If yes, please list:__________________________

Date of last dental visit: __________________ reason for today's visit ________________

Do you now have, or have you had any of the following? Please check yes or no for each.

Heart Disease ☐ yes ☐ no	Arthritis ☐ yes ☐ no	Tuberculosis ☐ yes ☐ no
High Blood pressure ☐ yes ☐ no	Tumor History ☐ yes ☐ no	AIDS or HIV positive ☐ yes ☐ no
Blood disease ☐ yes ☐ no	History of Substance Abuse ☐ yes ☐ no	Are you Pregnant? ☐ yes ☐ no
Rheumatic Fever ☐ yes ☐ no	Nervous Disorder ☐ yes ☐ no	**Allergy to any of the following?**
Cancer:____TYPE____ ☐ yes ☐ no	Radiation Treatment ☐ yes ☐ no	Antibiotics____TYPE____ ☐ yes ☐ no
Diabetes____TYPE____ ☐ yes ☐ no	Liver Disease ☐ yes ☐ no	Local Anesthetics ☐ yes ☐ no
Stroke ☐ yes ☐ no	Hepatitis____TYPE____ ☐ yes ☐ no	Latex ☐ yes ☐ no
Epilepsy ☐ yes ☐ no	Asthma ☐ yes ☐ no	Other____TYPE____ ☐ yes ☐ no

Remarks: ____

**I consent to whatever dental procedure and anesthetics are necessary for treatment of the above mentioned patient. I also agree to assume full financial responsibility for all treatment rendered.

Signature ______________________________ Date ________________

The Harmony Dental Group

161 EAST AVE STE 201 | NORWALK CT, 06851 | (203) 354-3193

Written Financial Policy

Thank you for choosing The Harmony Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options.

Payment is due at the time of service either in full or your out of pocket should you have insurance benefits.

Payment Options: You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note: For treatment plans of $50.00 or more, a 20% deposit is required to secure each appointment.

The Harmony Dental Group requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

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. Should your treatment be non-covered or the benefit estimate not paid in full the balance is your responsibility.

A fee is charged for patients who miss their appointment without 48-hour notice. The amount charged directly corresponds to the amount of the treatment scheduled for that appointment.

The Harmony Dental Group charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, 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.

The Harmony Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Information

Name: ____

Address ____

Telephone: ____

Section B: Purpose of Consent and Patient Approval/Signature

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this form. Our notice provides a description of the uses and disclosures we may make of your protected information. A copy of our notice is available upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Privacy Practices, including any revisions of our notice by contacting:

Contact Name: The Harmony Dental Group
Telephone: 203-354-3193
Fax 203-604-0199
Email: theharmonydentalgroup@gmail.com
Address: 161 East Avenue, Suite 201 Norwalk, CT06851

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice addressed to the contact name above. 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:__________________

If this consent is signed by a personal representative on behalf of the patient, print name below:

Personal Representative's Name:____
(Please print)