SCOTT F BOBBITT, DMD, MAGD, PA

Registration and Appointment Obligations

Patient Name____
Last **First** **MI** **(Preferred Name)**

Birth Date: MM/DD/YY____________________ **SSN:** ______________________ **(purpose: billing/account)**

Mailing Address: ____

____

Phones:
(Cell):____________________ **(Work):** ________________________**(Home):**_________________________

Would you like to be on our ASAP (As Soon As Possible) list? ☐ **YES**
This allows the scheduling manager to contact you should an earlier opportunity become available.

Do you have any preferences for your appointments?
☐ **Mornings** ☐ **Afternoons** ☐ **Earliest available** ☐ **Latest available** ☐ **No preference**

☐ **Mondays** ☐ **Tuesdays** ☐**Wednesdays** ☐**Thursdays** ☐ **No preference**

Communication about your Appointment: When you make a reservation with our office, you can expect we will do everything to carefully prepare for your care. In return, please respond to our confirmation emails or text messages by selecting the "CONFIRM" button; this action will interface with our schedule and notifies our front desk scheduling coordinator of your verification. Once you CONFIRM, the automated system will not continue to bother you with reminders, however, if you ignore them, they will continue to attempt to receive a confirmation from you. If you do not respond to the above nor have email or a cell phone on file, you will receive an automated phone call, please remain on the line during this call as it will prompt you to select a number to CONFIRM your appointment and this again will interface with our scheduling system. If you do not want to receive the plethora of options listed above, know that as soon as you CONFIRM one of these messages, then the sequence is stopped and we know you plan on being here. We prepare for your arrival 2 business days prior to your arrival. Our business week is Monday thru Thursday.

Our automated appointment reminder system is inclusive of email, text and automated phone call. Select the manner in which you prefer your reminders. You may select one or all. Thank you for your cooperation in understanding our confirmation system detailed above.

☐ **Email address:** ____ **(for appointment confirmations)**
☐ **Text reminders will use cell phone number above**
☐ **Automated phone calls will use home or cell phone number in your data file.**

Appointment Obligation: Should you be unable to keep your scheduled appointment, please call our office right away, **603-882-3001** so we have the opportunity to reach out to patients who are waiting for treatment. We have limited clinical time to offer, please help us use it effectively. The more notice we have, the more opportunity we have to utilize this time.

- To the best of my knowledge, all of the preceding information provided is true and correct.
- I will take the responsibility to inform the administration of any changes to keep my records current and up to date.
- I accept my responsibility to give the office at least 2 business days notice if I am unable to keep my reservation so the office has the opportunity to best use it's available clinical time.
- I give the office permission to contact me at the above address, phones or emails in order to perform the necessary duties involved in scheduling and communicating with me about my oral health care.

X____ Date: ____________________
Signature of patient, parent or guardian
If not patient, please print name and indicate relationship to Patient: ______________________________________

MEDICAL HISTORY

(PERSONAL AND CONFIDENTIAL)

Name: ____

Date of Birth: _________/_____/_________

Please Circle

1. Are you under the care of a physician? ………………………………………………………….…………….. Yes No
   a. If yes, for what treatment or reason: ____
   b. Primary Care Physician's (PCP) Name: ____
   c. Primary Care Physician's (PCP) Address: ____
   d. Date of last physical: ____
   e. Are you in good health? ………………………………………………………………………… Yes No
2. Have you been hospitalized in the last five (5) years: ……………………………………………….……… Yes No
   a. When? ________________ Reason? ____
3. Are you taking any medications? (prescription, over-the-counter, herbal, illicit, vitamins, other)………... Yes No
   a. If yes, please list here: ____
   ____
4. Have you had an allergic reaction to any medication, metal, latex or jewelry? ……………….…………… Yes No
   a. If yes, which ones? ____
5. Have you ever used diet drugs (*e.g.* Redux, Phenfen) ……………………………….………………. Yes No
   a. If yes, have you had an ultrasound heart exam? ………………………………….…………….. Yes No
6. Have you had trouble with prolonged bleeding after surgery? ……………………….…………..…… Yes No
7. Have you ever been diagnosed with cancer or a tumor? ……………………………….……….…….. Yes No
   a. If yes, what was your diagnosis: ____
   b. Did you receive chemotherapy? ………. Yes No Radiation therapy? ……………………... Yes No
   c. Date of last treatment: Month _______________ Year_____________
8. Have you ever taken medications for osteoporosis? …………..……………………………………….…… Yes No
9. Have you ever used tobacco products? ……………………………………………………………...…... Yes No
   a. If yes, how much did/do you smoke? ___________ Packs per day for ________Years
   b. If you are an ex-smoker, what year did you quit? ____________________________
10. Please circle "Yes" or "No" for any of the following conditions you may have or have had in the past:

Heart Attack …………...	Yes	No	Penicillin Reaction …….	Yes	No	Cold Sores ……..……...	Yes	No
Heart Murmur ……….....	Yes	No	Snoring/Sleep Apnea......	Yes	No	Substance Abuse ………	Yes	No
Heart Valve Problem…..	Yes	No	Daytime Sleepiness …...	Yes	No	Hepatitis ……..……...	Yes	No
Rheumatic Fever ……...	Yes	No	Kidney Trouble …….....	Yes	No	AIDS/HIV ……...........	Yes	No
Heart Disease ………….....	Yes	No	Thyroid Problem..……...	Yes	No	HPV …………………...	Yes	No
Heart Surgery ……….....	Yes	No	Asthma ………………...	Yes	No	Tuberculosis …………....	Yes	No
High Blood Pressure …...	Yes	No	Arthritis …………….....	Yes	No	Blood Transfusion….….	Yes	No
Pacemaker ... ……….....	Yes	No	Allergies/Hives ………...	Yes	No	Anemia ………………...	Yes	No
Angina Pectoris ……..…	Yes	No	Emphysema ……….…...	Yes	No	Bruise Easily …….…....	Yes	No
Stroke ………………….	Yes	No	Dry Mouth ……..……...	Yes	No	Bleeding Problems ….....	Yes	No
Diabetes ………...........	Yes	No	Gum/Mouth Surgery …..	Yes	No	Psychiatric Care …….....	Yes	No
Ulcers …………….........	Yes	No	Epilepsy/Seizures ……...	Yes	No	Anxiety/Depression ……	Yes	No
GERD/Reflux/Heartburn .	Yes	No	Fainting/Dizziness ….....	Yes	No	Artificial Joints ………...	Yes	No

11. Do you have any disease, condition or problem not listed above? …………………………………….…....Yes No
    a. If yes, please list here: ____
12. **WOMEN:** Are you pregnant? … Yes No Nursing? ……Yes No Taking Birth Control Pills? ... Yes No

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To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change(s) in my health, I will inform the doctor at the next appointment without fail.

X____ **Date:** _____________ **Staff:** _____________

(Signature of patient, parent, or guardian)

EMERGENCY CONTACT (Name and phone number): ____

FOR STAFF USE

Payment Obligations

Please come prepared to make a payment each time you are seen in the office for service provided regardless of insurance coverage.

- **Cash, Check, Debit card, Major Credit Cards** (VISA, MasterCard, Discover, American Express)
- **Online Secured Patient Portal:** secure online payments can be made on our website, www.DrBobbitt.com, Register in the patient portal located at the top of home page of our practice website.
- **Insurance Electronic Claim Service**
  - Is used in conjunction with payment of estimated **Copayments/Office Visit Copayments**
  - Presenting your current dental benefits card upon arrival ensures updated insurance data on file
  - Know your plan's maximum, exclusions, waiting periods and deductibles as the office nor does your carrier guarantee coverage.
  - We expect electronic claims to be paid within 10-15 days of their submission; delays may result in seeking payment from said patient.

Accounts Department:

Statements: Payment is requested promptly and no later than the statement due date. Consider using our secure online option.

Senior Citizens (65+) Courtesy: Non-insured seniors (age 65+) are eligible for up to a 10% courtesy that meet the following:

- Hygiene appointments are scheduled between 11AM-2PM
- Payment in full is made same day in CASH or CHECK and carry no account balance
- Senior Courtesy cannot be combined with insurance, courtesy, reduction or any other offer

Payment Plans: **(please coordinate these arrangements in advance with our accounts department)**

- **3rd Party Financing:**
  www.CareCredit.com, **www.LendingClub.com** or **www.CitiHealthCard.com** offer short and long term payment plans suitable for budget planning. Applicants are encouraged to apply online and are subject to credit approval prior to utilizing this option.
- **In Office Layaway Payment Plan:** arranged in advance with the Accounts Department or Office Manager; 50% retainer is requested for appointment reservation.

Payment Solutions:

Payment delays should be discussed with the Accounts Department in a timely manner so that we can be afforded the time to assist you in setting up a payment solution plan to resolve your payment obligation.

Out of Compliance and Delinquent Accounts:

When financial obligations listed above are not met, these accounts will be assessed the following fees and charges:

- **Late Fee**: is assessed when payment is not received by the due date.
- **Finance Charge:** at the Periodic Rate of 2% per month or 24% APR(Annual Percentage Rate) is automatically assessed to any balances aged to 60+ days from the date of service regardless of insurance benefits/delayed claim, or payment plans or solution plans that are not fulfilled.
- **Returned checks:** Fees incurred by the practice for a returned bank check will be assessed to the outstanding account.
- **Delinquent Accounts:** The Accounts Department will make efforts to communicate with you on a 60 and 90 day past due level. Please respond to our efforts to secure communication and payment solution. If no payment solution is reached, the delinquent account will be accessed a 35% service and handling fee on the balance on acct before turning the account over to a collection agency. This submission will affect your credit rating. Any patients related to a collection agency submission will be dismissed from the practice.

Authorization, Release, Signature on File:

- I take the responsibility to keep my personal contact and billing information on file current and up to date.
- I am authorized and do grant my permission to you or your assignee, to communicate with me by telephone/email/fax during daytime hours at work or home to discuss matters related to this form.
- I understand you have asked me to come prepared to make requested payments on the day I receive services and will fulfill my financial obligation to this office to pay for services rendered regardless of insurance involvement.
- My Signature on File is my authorization for the release of information necessary to discuss treatment recommendations or referral discussions with other health practitioners.
- My Signature of File authorizes Scott F. Bobbitt, DMD, Professional Association to process claims, including any information regarding the diagnosis, records of any examination or treatment rendered during the period of such dental care to third party payers and/or other health practitioners. I hereby authorize payment of the insurance benefits for services rendered, otherwise payable to me, to: Scott F. Bobbitt, DMD, Professional Association.

Name Printed:	Signature:	Date:

BENEFIT CARRIERS you would like us to send claims to on your behalf:
Please provide benefit cards for the coverage listed below so that we can scan them for your record.

DENTAL Benefit Carrier/Address:____

____

Dental Carrier 1-800 Telephone contact #: ___________________________________

Patient's relationship to insured: ☐ Self ☐ Spouse/Partner ☐ Child/Dependent ☐ Other __________________

Subscriber:____
Last First MI

Subscriber's Birth Date: ________________ ID #: ____________________ Group #:__________________________

Subscriber's Address____
Street City State Zip Code

Subscriber's Employer:____

If patient is a Full Time College Student, list University/College name/City, State: _______________________________

MEDICAL Benefit Carrier/Address:____

____

Medical Carrier 1-800 Telephone contact #: ___________________________________

Patient's relationship to insured: ☐ Self ☐ Spouse/Partner ☐ Child/Dependent ☐ Other __________________

Subscriber:____
Last First MI

Subscriber's Birth Date: ________________ ID #: ____________________ Group #:__________________________

Subscriber's Address:____
Street City State Zip Code

Subscriber's Employer: ____

Dental Records Release Form

Patient Transferring: ____

Date of Birth: _______/_______/_______ Telephone Number: (_____) ________________

Current Address: ____

____

☐ **Transferring records out of Dr. Bobbitt's office to a new provider:**

New provider's name: ____

Address: ____

Office email : ____

- ☐ I prefer to pick up my duplicated dental records. (Please allow 1 week for duplication)
  - ☐ Please attach $15 to cover the cost of duplicating your records/history/x-rays. Check # ___________
  - ☐ Credit card payment info:

____

Print name as it appears on card   Card Number

____

Expiration Date   (CVV) 3 digits /back of card   Signature

☐ **Transferring records into Dr. Bobbitt's office:**

My previous dental provider's information:

Dentist or Office Name: ____

Address: ____

Email (print clearly*) or phone contact:____

Please send digital records to: Admin@DrBobbitt.com
We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email. Encrypted email is not currently available so please plan the time necessary for mailing records accordingly.

I hereby grant permission to **SCOTT F. BOBBITT, DMD, PROFESSIONAL ASSOCIATION**, to release or obtain information related to my dental/medical history, clinical notes and x-rays/photos to the above noted recipient.

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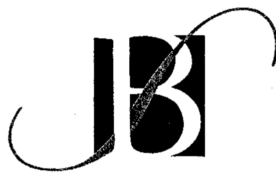
Patient Signature (parent if minor)   **Date**
According to NH State Law, your original records are property of this office and will remain in safe keeping for seven years.



Scott F. Bobbitt, DMD, MAGD

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge the opportunity to review **Scott F Bobbitt, DMD, PA Notice of Privacy Practices**. I understand I may request a copy of the practice's Notice of Privacy Practices should I desire.

Patient's Printed Name ______________________________

Signature of Patient or Guardian______________________________**Date**__________

Print Name of Guardian/Personal Representative______________________________

Relationship to Patient__________________

* You May Refuse to Sign This Acknowledgment*

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 (Please Specify)

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