Kathleen Perkins, DMD
106 Main Street, Suite 5
Stoneham, MA 02180

We are pleased to welcome you to our practice! Please take a moment to fill out this form completely. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health to the highest standard of care.

Patient Name:		
Social Security #	Date of Birth:	Sex: ☐ M ☐ F
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced		
Address:		
City:	State:	Zip Code:
Home:	Mobile:	Work:
Email Address:		
Employer:		
Whom may we thank for referring you?		
Emergency Contact:		Phone #

Primary Dental Insurance Information

Person Responsible for Account:		
Date of Birth:	Social Security #	(Required to Verify Insurance)
Relationship to Patient:		
Address:		
City:	State:	Zip Code:
Home:	Mobile:	Work:
Email Address:		
Employer:		

Insurance Company:		
Subscriber I.D. #		Group I.D. #
Names of Other Dependents Covered by this Plan:		
Secondary Dental Insurance Information		
Is patient covered by additional insurance? ☐ YES ☐ NO		
Person Responsible for Account:		
Date of Birth:	Social Security #	(Required to Verify Insurance)
Relationship to Patient:		
Address:		
City:	State:	Zip Code:
Home:	Mobile:	Work:
Email Address:		
Employer:		
Insurance Company:		
Subscriber I.D. #		Group I.D. #
Names of Other Dependents Covered by this Plan:		

Please be advised we bill your insurance as a courtesy to our patients. Dental Insurance is a contract between your employer and you. The extent of coverage varies greatly from company to company. Despite our best efforts at giving you an accurate estimate, this is not a guarantee of payment and a patient will owe the amount of the difference. We request payment for your portion at the time of service and will gladly offer several methods of payment. Please feel free to ask any staff member if there is anything we can do to help service you.

Patient Signature: ____ Date: __________________

Dental Insurance Information

Our entire staff is pleased that you have insurance benefits to help you and your family with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the following information on our insurance claims process so that we can work together to ensure this benefit.

Do you accept my insurance? How much will they pay?

We currently accept a variety of private care insurance plans, which means that we work with many companies. Although we maintain computerized histories of payments by a given company - they do change, therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up to date information we have, <u>but this is only an estimate</u>.

I thought I paid my portion, but you sent me a bill. Why?

We base the patient portion of your bill on our most current information, but there are several factors that can affect the estimate. For example, there may be a deductible, a policy mandated service downgrade, or you may have received treatment in another office prior to treatment in our office. Insurance companies do not inform us of changes in your benefits. We do however, investigate your benefits to the best of our abilities.

Insurance did not pay, now what?

We bill your insurance as a courtesy. Dental insurance is a contract between your employer and you. The extent of coverage varies greatly from company to company, sometimes even within the company itself. It has absolutely nothing to do with the level of service provided by this office, or the fee charged for these services. Despite our best efforts at giving you an accurate estimate, a patient will occasionally owe the amount of the difference after insurance has paid. Again, this has nothing to do with the fee charged, rather with the level of coverage negotiated by your employer and decided upon by the insurance company.

Financial Options

We request payment for your portion at the time of service. We do have several methods of payment that are designed to help you and your family get the quality of dental care that you deserve. Please feel free to ask any staff member if there is anything we can do to service you.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile that you deserve.

I have read, understand and accept the terms of the above outlines policies for insurance handling and financial commitments that I may incur as result of treatment.

Patient Signature: ____ Date: __________________

HIPAA Consent

I have had full opportunity to read and consider the contents of this consent. I understand that by signing this form, I am confirming my written permission for the disclosure of my protected health information as described in this form.

Printed Patient Name: ____

Patient Signature: ____ Date: _________________

X-Ray Release for Referral Treatment

In the case of the upcoming need of a referral to another dental provider, I give permission to the office of Kathleen Perkins, DMD to release necessary x-rays.

Printed Patient Name: ____

Patient Signature: ____ Date: _________________

Appointment Cancellation Policy

Dr. Kathleen Perkins is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.
Please call us within 48 hours prior to your scheduled appointment to notify us of any changes or cancellations.

To cancel a Monday appointment, please call our office by 2 PM on Friday. If prior notification is not given, you will be charged $50.00 for the missed appointment.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Printed Patient Name: ____

Patient Signature: ____ Date: _________________

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and call of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Risks of Dental Procedures in General

I understand that the risks of dental procedures include, but are not limited to, complications resulting from the use of dental instruments, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness in the lip, tongue, chin, gums, cheeks, and teeth, reaction to injections, change in occlusion (bite), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restorations in teeth, injury to other teeth, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruising, delayed healing, sinus complications, and further surgery. Certain medications may cause drowsiness and last of awareness and coordination, thus it is advisable not to operate any vehicle or hazardous device for 24 hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment in may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

I certify that I have read and fully understand the above consent to dental treatment, anything that I did not understand was explained to me.

Printed Patient Name: ____

Patient Signature: ____ Date: _________________

To whom it may concern:

This is a request for your office to release my dental records and forward all necessary information including x-rays to:

Name of Practice:	Kathleen Perkins, DMD
Address:	106 Main Street, Suite 5
	Stoneham, MA 02180
Telephone:	(781) 438-1003
Email:	kathleenperkinsdmd@gmail.com
Fax:	(781) 435-1996

Provider of Records

Name of Practice:
Address:
Telephone:
Email:
Fax:

Printed Patient Name: ____

Patient Signature: ______________________________________ **Date:** _____________