17 Lafayette Street
Norwich, CT 06360
Tel: 860.886.2497
Fax: 860.886.6591

Norwich Family Dental
ASSOCIATES

Richard T. Snayd, D.D.S.
Ted B. Fischer, D.M.D.
Matthew D. Amaro, D.M.D.
Michael E. Dunne, D.M.D.

Please fill out completely

Patient Name: _____

Mailing address_____

Telephone #_____ cell #_____

Email Address: _____ Marital status: SINGLE/ MARRIED/OTHER

INSURANCE: YES / NO

PRIMARY INSURANCE: (*please fill out completely*)

Person with Insurance: _____ Date of Birth _____Social Security #_____

Insurance Carrier: _____Employer: _____Phone: _____

Policy/Group#: _____ Relationship to Patient: _____I.D.# _____

SECONDARY INSURANCE: (*please fill out completely*)

Person with Insurance: _____ Date of Birth _____Social Security #_____

Insurance Carrier: _____Employer: _____Phone: _____

Policy/Group#: _____ Relationship to Patient: _____I.D.# _____

I authorize the release of any information necessary to process insurance claims for Dental benefits. I authorize payment of my benefits to: Norwich Family Dental Associates

Signature:

_____Date:_____

OFFICE POLICY INFORMATION:

I UNDERSTAND I WILL BE CHARGED FOR FAILED APPOINTMENTS AND APPOINTMENTS CANCELLED **WITHOUT** 24 HOURS NOTICE. _____(initial)

I UNDERSTAND ALL CO-PAYMENTS ARE DUE AT THE TIME TREATMENT IS RENDERED, ALSO THIS CHARGE IS ESTIMATED AND I MAY BE BILLED ANY PORTION UNPAID BY MY INSURANCE. _____ (initial)

I UNDERSTAND THAT REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR PROFESSIONAL TREATMENT RENDERED, AND I UNDERSTAND YOUR OFFICE CHARGES 18 % INTEREST ON ACCOUNTS OVER 60 DAYS, AND IF NECESSARY, COLLECTION FEES ARE ADDED TO DELINQUENT ACCOUNTS.

SIGNATURE: _____ (PRINT NAME)_____Date: _____

ACKNOWLEDGEMENT OF NOTICE OF NORWICH FAMILY DENTAL ASSOC. PRIVACY PRACTICES

I, _____, have read a copy of Norwich Family Dental Associates' Notice of Privacy Practices. I have
(Print name) obtained a copy of the Norwich Family Dental Associates privacy practice per my request.

Signed: _____ Date: _____
(Signature of patient or legal guardian)

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 __ an emergency situation prevented us from __ communication barriers prohibited
__ Other (please specify) obtaining the acknowledgement obtaining the acknowledgement rev04092010DT