


Welcome To WATERTOWN Dental Care

We are delighted and honored that you have chosen us to provide your child with the best dental care possible. We love  to treat children in our practice!

The first visit to the dentist may be the most important one in your child's life. It's an experience that will help determine and motivate life-long dental health. That's why we go slowly, and take all the time your child needs to feel comfortable. We will do our very best to make your child's dental visit an enjoyable and positive experience. We promise to deliver the highest standard of care, and we welcome all of your questions. Rest assured, most of our team members have children of their own, and we think your children are just as precious as ours.

Whether or not you're allowed to enter the treatment area with your child is a common dental question many parents have -- and there's not always a cut-and-dry answer. The fact is, whether or not a parent or guardian accompanies their child to the dental operator often depends on the child's individual situation. The American Academy of Pediatric Dentistry recommends that parents of older children remain in the waiting room when children are brought into the dental operator. Infants and some young children may benefit from having one of their parents in the operator with them, but it's usually in a child's best interest to be treated without parental interference. Studies have shown that children over the age of 3 often respond better to dental treatment when their parents aren't in sight.

Generally speaking, we invite you to stay with your child during the initial examination. During the initial visit, your toddler might sit on your lap, or next to you, in the dental chair to help put him or her at ease. On subsequent visits, typically most children will be more cooperative when unaccompanied by a parent or guardian. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome any apprehension towards dental treatment.

Of course, we understand that every situation is different. We have advanced training specific to meeting the unique dental needs of children, so you can feel confident that you're leaving your child in excellent hands. By allowing your child to enter the operator without you, you're placing trust in our office and teaching your child to do the same.

As parents, we are often more apprehensive than our children when it comes to their appointments, so care must be taken not to appear overly concerned. For example, statements such as "Don't worry," or "It won't hurt," can do more harm than good. Children can sense parent's anxiety and discomfort. Using words of encouragement such as "This will be fun," or "It feels good to have healthy teeth," are just a few examples to help them understand that going to the dental office will be a positive experience.

We appreciate you choosing Watertown Dental Care to care for your family. We are passionate about Oral Health and love sharing that passion with all of our patients—young and old—and instilling a lifetime of oral health!

We look forward to meeting you.

Darin Bach, DDS, FAGD, Diplomate, American Board of Dental Sleep Medicine
Hally Bach, DDS
Clayton Conroy, DDS

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Patient Registration

Patient's First Name: _____ **M** _____ **Last** _____ **Today's Date:** _____

Birth Date: _____ **Age:** _____ **SSN:** _____ **Sex:** ___ M ___ F **Full Time Student?** ___ Yes ___ No

Please check one: ___ Single ___ Married ___ Separated ___ Divorced ___ Widow **Email:** _____

Home Address: _____ **City:** _____ **State:** ___ **Zip:** _____ **Employer:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Medical Contacts: Watertown Dental Care coordinates treatment with your other medical providers when needed to ensure maximum benefit to you. Please list your other medical providers.

Primary Care Physician: _____ **Sleep Doctor:** _____

Other Specialist: _____ **Other Specialist:** _____

Minor Children (If you would like to register them for care):

First Name: _____ **M** _____ **Last** _____ **Birth Date:** _____ **Sex:** ___ M ___ F

First Name: _____ **M** _____ **Last** _____ **Birth Date:** _____ **Sex:** ___ M ___ F

First Name: _____ **M** _____ **Last** _____ **Birth Date:** _____ **Sex:** ___ M ___ F

How Would You Like To Be Contacted About Appointments? ___ Telephone ___ Email /Text

May we contact you via home phone and/or cell phone in regard financial questions and information? ___ Yes ___ No

How Did You Hear About Our Office? ___ Mailed Offer ___ Newspaper ___ Radio ___ Walk-In ___ Website/Social Media ___ Phone Book

___ Billboard **Personal Referral (Name: _____)** ___ Special Event (_____)

Dental Insurance Information (Primary Carrier)

Insured's Name: _____

Relationship to Patient: _____

DOB: _____ **SSN:** _____

Insured's Employer: _____

Insurance Company: _____

Ins. Co. Address: _____

Phone #: _____

Group #: _____

ID #: _____

Secondary Carrier (if applicable)

Insured's Name: _____

Relationship to Patient: _____

DOB: _____ **SSN:** _____

Insured's Employer: _____

Insurance Company: _____

Ins. Co. Address: _____

Phone #: _____

Group #: _____

ID #: _____



Patient Registration

Missed Appointments

Please help us to serve you and all of our patients best by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us three business days' notice.

Insurance

In most cases, we are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and estimate your portion for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage. You are responsible for knowing your benefit details.

I hereby authorize my insurance company to assign benefits directly to the office of Drs. Darin and Hally Bach, D.D.S., P.C. I understand that I am responsible for all costs of dental treatment. I authorize Watertown Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the information I have provided on the Patient Registration Forms and Dental and Medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I also authorize the use of this signature on all insurance submissions.

Financial Policy

Thank you for choosing Watertown Dental Care as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides the very best of care in the most pleasant environment.

In order to make financial arrangements for your treatment, we offer several flexible options. We accept cash, checks, Visa, MasterCard, Discover, and American Express as well as extended payment plans upon credit approval. By signing below you understand and agree that you are financially responsible for all charges associated with this account.

Print Name: _____ Signature: _____ Date: _____

Summary of Notice of Privacy Practices

Watertown Dental Care keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect, and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice.

You have a right to a copy of this "Notice" Please check your option below:

I am requesting a copy of the Watertown Dental Care "Notice of Privacy Practices"

I do not wish to receive a copy of the Watertown Dental Care "Notice of Privacy Practices at this time. I reserve the right to request a copy at a later date.

I have had a full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

Print Name: _____ Signature: _____ Date: _____

Patient Registration

Informed Consent:

By signing below, you are consenting to treatment, as well as acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. You are acknowledging the understanding that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not visible during examination, and you give your permission for those changes.

Verification of Guardians Authorized to Consent to Dental Treatment:

It generally is understood that the person granting consent for dental treatment is the patient, and of the legal age to do so. However, for patients under the age of majority or adults with diminished mental capacity, informed consent should be obtained from a parent (see above). After the initial visit, we understand that it may sometimes be necessary to arrange for a non-legal guardian to attend a dental appointment with a pediatric patient or adult with diminished mental capacity. These may not be a legal guardian allowed by law to consent to medical procedures. Examples of such an adult include a grandparent, step-parent, noncustodial parent in instances of divorce, babysitter, or friend of the family. A child in foster care or a ward of the state may be accompanied by a caretaker who may or may not be allowed to consent to medical procedures, according to individual state law.

As a parent, I give my permission for the following non-legal guardians to give consent for any and all dental procedures in my place, and I understand I will be financially responsible. I also understand that this permission is valid until I cancel it in writing:

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

(If any of the above individuals have power of attorney, please provide the office with a copy)

EXECUTION AND EFFECTIVE DATE

PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

Patient Registration

Are you covered by Medicare? No (You may skip this section) Yes, Please complete the following:

PRIVATE CONTRACT WITH PATIENT
(OPT-OUT OF MEDICARE)

PARTIES & RECITALS:

- A. This is a Private Contract between Dr. Darin Bach, DDS, Dr. Hally Bach, DDS, and Dr. Clayton Conroy, DDS (DBA: Watertown Dental Care) and _____ (patient) which allows dentist to provide treatment to patient without being subject to Medicare limits. To do so, the law requires dentist to "opt-out" of Medicare and that no Medicare claim be filed for the treatment of patient by dentist.
- B. Drs. Bach, Bach & Dr. Conroy are not excluded from Medicare under Sections 1128, 1156 or 1892 or any other section of the Social Security Act.
- C. Drs. Bach, Bach, & Conroy have elected to opt-out of the Medicare program, effective May 26, 2015 and will not be eligible to participate in the program again until May 26, 2017.

AGREEMENTS:

- A. Patient or his or her legal representative accepts full responsibility for payment of Drs. Bach, Bach, & Conroy's charge for all services furnished by Drs. Bach, Bach, & Conroy.
- B. Patient or his or her legal representative understands that Medicare limits do not apply to what Drs. Bach, Bach, & Conroy may charge for services.
- C. Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask Drs. Bach, Bach, & Conroy to submit a claim to Medicare
- D. Patient or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by Drs. Bach, Bach, & Conroy that would have otherwise been covered by Medicare, if there was no private contract and a proper Medicare claim had been submitted.
- E. Patient or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare covered items and services from physicians, dentists, or practitioners who have not opted-out of Medicare, and the patient is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians, dentists or practitioners who have not opted-out. _____ **INITIAL HERE**
- F. Patient or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- G. Patient or his or her legal representative warrants and represents that Patient does not currently require emergency care services or urgent care services.

EXECUTION AND EFFECTIVE DATE



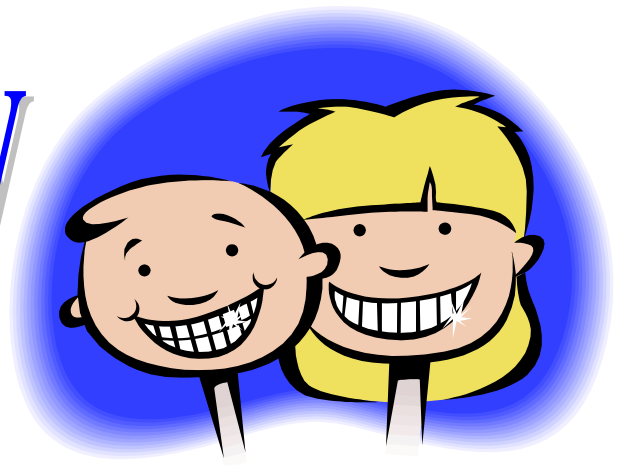
DENTIST SIGNATURE

PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

**Original Contract Must Be Retained by Drs. Bach, Bach, & Conroy.
A Copy Will Be Provided to Patient upon request.**

Health History



Dental History

- Has child complained about dental problems? YES NO
Does child brush teeth twice daily? YES NO
Does child use floss daily? YES NO
Does child drink fluoridated water? YES NO
Has child ever received orthodontic treatment? YES NO
Has child ever had any mouth, tooth, or head injuries? YES NO
Has child ever had any unhappy dental experiences? YES NO

Does child have any mouth habits—thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc...? YES NO

Previous Dentist: _____ City: _____ State: _____

Date of last dental visit: _____ For what service: _____

Medical History

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is child under a physician's care now? YES NO _____

Has child ever had surgery or been hospitalized? YES NO _____

Physician's name and address: _____

Is child taking any medications, pills, drugs, herbal supplements, etc...? (If yes, please list all below.) YES NO

ALLERGIES (please circle): Aspirin Penicillin Codeine Acrylic Latex Metal Food Local Anesthetics

Other: _____

Does your child have, or has he/she ever had, any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Heart trouble/disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fainting spells/Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cold sores/Fever blisters | <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Herpes | <input type="checkbox"/> |
| Stomach/Intestinal Disease | | | | |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |

Have you ever had any serious illness not listed above? YES NO (If yes, please explain : _____)

Additional comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient (or Parent/Guardian)

Print name

Date

Signature of Doctor

Date