Webster Dental Associates
40 Webster Street
Manchester, NH 03104
(603) 669-4252

Directions to our office

Going Route 93 North

Go 93 North to exit 9 South.
Go straight off the exit and you will be on Daniel Webster Highway.
Go to the 3rd set of lights, Dunkin' Donuts will be on your Right.
Take a right onto Webster Street.
We are on the right side of the road ½ mile down, next to Fire Station.

Going Route 293

Go 293
Take exit 6, Amoskeag Bridge
Bear Right off the exit (go over Amoskeag Bridge)
After you bear right, go to your 2nd set of lights
At the 2nd set of lights, take a Left onto Elm Street
Go to 1st set of lights and take a Right onto Webster Street
We are on the left side of the road, next to Fire Station.

Webster Dental Associates

40 Webster Street
Manchester, NH 03104
Office: (603) 669-4252
Fax: (603) 641-2835

Please contact our office immediately if you have any of the following:

Heart Murmur
Artificial Knee
Artificial Hip
Any Joint Replacement
Surgery that required Pins/Plates
Mitral Valve Prolapse
Endocarditis

As you may require an antibiotic before any of your dental appointments.

Please forward any previous dental records &
xrays to us at the following email address:

websterdentalassoc@gmail.com

Webster Dental Associates
Medical History

Name: _____ **Date Of Birth:** _____/_____/_____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____) _____-_____ **Cell:** (_____) _____-_____

E-Mail Address: _____ **Social Security #:** _____/_____/_____

Emergency Contact: _____ **Phone Number:** (_____) _____-_____

Primary Care Physician: _____ **Phone Number :** (_____) _____-_____

Physicians Address: _____ **City/State:**_____

Dental Insurance: _____ **Name of Policy Holder:** _____

Employer: _____ **Address:** _____

Member I.D. #:_____ **Group Number:** _____

Although dental personnel 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.

Are you under physicians care now? _____ **yes** _____ **No** **If yes please explain:** _____
Have you ever been hospitalized or had any major operations? _____**Yes** _____ **No If yes please explain:** _____
Have you ever had any serious head or neck injury? _____ **Yes** _____ **No If yes please explain:** _____
Are you taking any medication? _____ **Yes** _____ **No If yes Please Explain:** _____
Do you take, or have taken Phen-Fen or Redux? _____ **Yes** _____ **NO** _____
Are you on a special Diet? _____
Do you use tobacco? _____ **Yes** _____ **No** **((Women)) Are you pregnant or trying to get pregnant?** _____ **Yes** _____ **No**
Do you use controlled substance? _____ **Yes** _____ **No** _____ **Nursing** _____ **Taking oral contraceptive**
Do your gums bleed? _____ **Yes** _____ **No**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?
_____ **Asprin** _____ **Penicillin** _____ **Codeine** _____ **Acrylic** _____ **Metal** _____ **Latex** _____ **Local Anesthetics** _____ **Sulfa**

_____ **Other ((If Yes Please Explain))** _____

DOES YOUR DOCTOR REQUIRE YOU TO TAKE PRE-MED BEFROE ANY DENTAL PROCEDURES? _____ **Yes** _____ **NO**
IF YES PLEASE EXPLAIN: _____

DO YOU HAVE ANY OF THE FOLLOWING?

____ AIDS/HIV positive	____ Chest Pains	____ Frequent Headaches	____ Irregular Heart Beat	____ Scarlet Fever
____ Alzheimers Disease	____ Cold Sores / Fever Blisters	____ Genital Herpes	____ Kidney Problems	____ Shingles
____ Anaphylaxis	____ Congenital Heart Disorder	____ Glaucoma	____ Leukemia	____ Sickle Disease
____ Anemia	____ Convulsions	____ Growths	____ Liver Disease	____ Sinus Trouble
____ Angina	____ Cortisone Medicine	____ Hay Fever	____ Low Blood Pressure	____ Spinal Bifida
____ Arthritis / Gout	____ Diabetes	____ Heart Attack/Failure	____ Lung Disease	____ Stomach Disorder
____ Artificial Joint	____ Drug Addiction	____ Heart Murmur	____ Mitral Valve Prolapse	____ Stroke
____ Artificial Heart Valve	____ Easily Winded	____ Heart Pace Maker	____ Pain In Jaw Joint	____ Swelling of Limbs
____ Asthma	____ Emphysema	____ Heart Trouble/Disease	____ Parathyroid Disease	____ Thyroid Problem
____ Blood Transfusion	____ Epilepsy	____ Hemophilia	____ Psychiatric Care	____ Tuberculosis
____ Bruise Easily	____ Excessive Bleeding	____ Hepatitis A, B, or C	____ Recent Weight Loss	____ Ulcers
____ Cancer	____ Fainting Spells/Dizziness	____ High Blood Pressure	____ Renal Dialysis	____ Venereal Disease
____ Chemotherapy	____ Frequent Cough	____ Hives or Rash	____ Rheumatic Fever	____ Yellow Jaundice
	____ Frequent Diarrhea	____ Hypoglycemia	____ Rheumatism	

HAVE YOU HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ____ **Yes** ____ **No** **IF YES EXPLAIN:** _____

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.

PLEASE BE AWARE THAT OUR OFFICE DOES REQUIRE A 24 HOUR NOTICE TO CANCEL AN APPOINTMENT. IF WE DO NOT RECEIVE A 24 HOUR NOTICE YOU WILL BE CHARGED A $100.00 LATE CANCELLATION FEE.

SIGNATURE OF PATIENT OR GUARDIAN: _____ **DATE:** _____/_____/_____

Notice of Privacy Practices Acknowledgement (HIPAA)

Patient Name:_____ Date of Birth:_____/_____/_____

I have received this practice's notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I may exercise these rights in relation to:

    - The right to complain to this practice and to see Secretary of HHS if I believe my rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to request restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the term of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Privacy Practices on request.

Signature:_____ Date: _____/_____/_____

Relationship to patient (if signed by a personal representative of patient): _____

Information about Payment and Insurance

Thank you for choosing us as your dental health provider. We are committed to providing you with the best possible dental care at the lowest possible cost. In order to achieve these goals we need your assistance, and your understanding of our payment and insurance practices.

Payment Arrangements

Full payment for professional services is due at the time of service. We accept cash, checks, and major credit cards. With prior approval, we also offer a choice of interest-free or extended payment plans to qualified applicants through our financial partner, Care Credit. Please ask us in advance of your treatment if you are interested in applying for Care Credit.

Regarding Insurance

If you have dental insurance coverage, we will be glad to help you receive your maximum allowed benefits and will file the claim for you as a courtesy. In most instances we will accept assignment of insurance benefits: however, **we reserve the right not to accept assignment of benefits** from insurance carries that our experience has shown reimbursement on an un-timely basis. **If we do not accept assignment, all co-payment are due at the time of service. Should your carrier pay less then what is expected, deny the claim, or pay you directly you will be responsible for payment of the balance. Your insurance is a contract between you, your employer and your insurance company**. Hence, the insurance company is responsible to you and you are responsible to us.

Many times claims will take up to 30 days to be paid to us. If our efforts to collect insurance payment are unsuccessful, you will be asked to assist us in resolving the problem. **If your insurance company has not paid your account in full within 45 days, you will be held responsible for the balance.**

Usual and Customary Fees

Please be aware that few insurance companies attempt to cover all dental costs. Many dental insurance plans set limits for fees or maximum allowable amounts for services which they indicate they will pay 100%. These are referred to as *usual and customary fees*. It is important to note that these fees may not reflect the "usual customary fee" for our area, but are more of a limit the insurance carrier places on its liability. If these fees are less than our fees you will be responsible for the difference.

Treatment Estimate and Insurance

Based on the information we received from you, your insurance carrier, or benefit information we may have on your employer, we will give you a treatment estimate on what you can anticipate your co-payment to be. **Please understand that these are only estimated**. Webster Dental does not presume to act as a representative of your insurance carrier. If you have a large treatment plan and would like us to submit a pre-treatment estimate to your insurance please ask us. This is still not a guarantee of benefits but is more accurate. We will not know the benefit amounts available until actual payment from your insurance carrier is received.

White fillings (bonding)

White fillings on posterior (back) teeth may or may not be covered by your insurance. Some insurance companies may only pay a silver filling benefit which means that you **may have a higher out-of-pocket expense.** The estimate we give you is our best attempt at discerning what they may pay. Whatever the case, you are responsible for payment of the balance.

AS A COURTESY WE PROVIDE TEXT, EMAIL OR CALL 2 DAYS IN ADVANCE TO CONFIRM YOUR FUTURE APPOINTMENTS. PLEASE UPDATE YOUR CONTACT INFORMATION AS NEEDED.

MISSED APPOINTMENTS OR CANCELLATION WITH LESS THEN 24 HOURS NOTICE, WILL BE SUBJECT TO A $100.00 FEE.

Signature_____ **Date**_____

Warranty

We are proud of the dental services we provide and we are proud to stand by our work. This warranty remains valid only if you come in for your regular check-up and cleaning every four–six months and x-rays one time per year as recommended by Dr. Golparvar.

1. We will replace any defective filling with the equivalent restoration **FREE** for up to two years after it is placed by Dr. Golparvar.

2. We will replace any crown that needs replacing for up to five years with an equivalent crown at **NO CHARGE** to you as long as it was initially done by Dr. Golparvar.

Regarding insurance billing

As a courtesy, our office will submit all claims to your dental insurance regardless if we are in or out of network with them. If you do have dental insurance our office will try to calculate an accurate estimate on your out of pocket expense. However if the insurance company does not pay the full amount that our office estimates them to pay, or they downgrade services in any way (for example they pay only towards silver fillings on posterior teeth), it will be your responsibility to pay the balance due to our office. This is explained thoroughly in our in our explanation of insurance form.

Signature:_____ **Date:**_____/_____/____

See your new Invisalign® smile in seconds.

Scan the QR code to see your smile transformation.

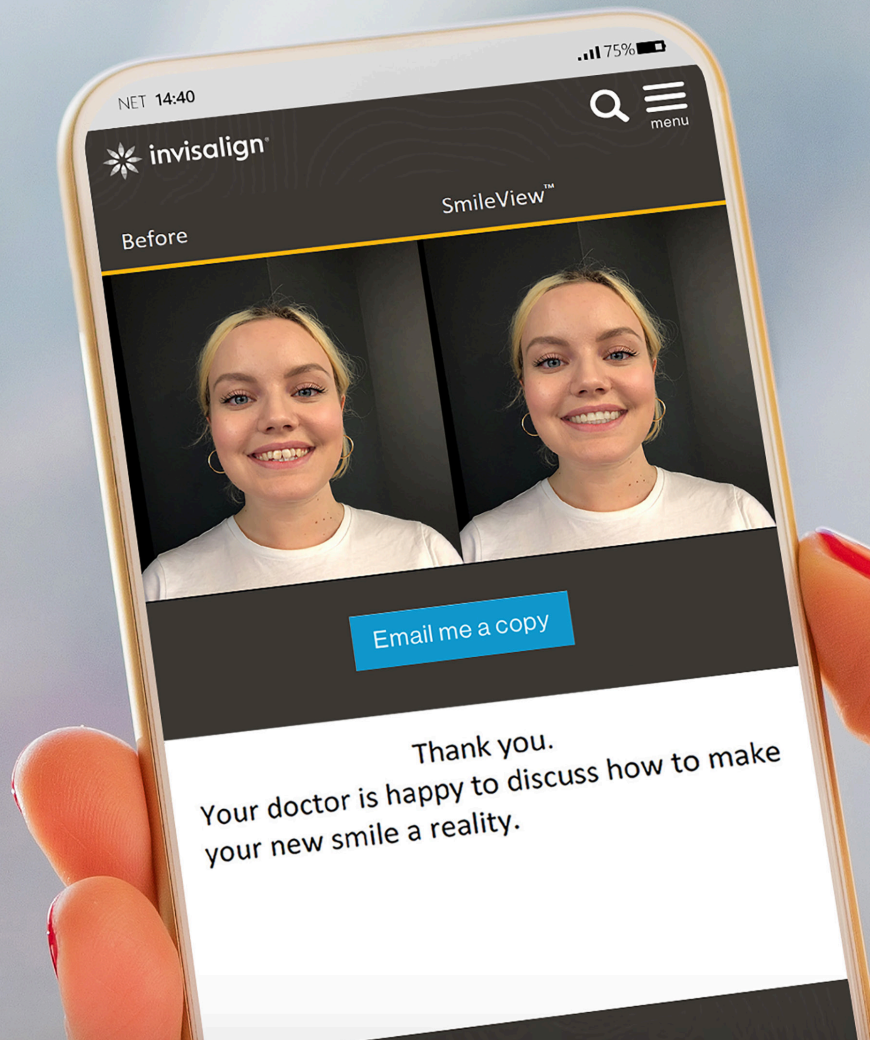
01 Get your phone

02 Open your camera

03 Point it at the QR code

04 Snap your selfie

05 See your new smile



WEBSTER DENTAL ASSOCIATES

invisalign® PROVIDER