10 Doane Street, Bradford, MA 01835-7405
Telephone (978) 372-6800 www.adhdds.com

Welcome to our office!
Our staff consists of three dentists, **Dr. Parsia Koleini, Dr. K. Bruce Riedell** and **Dr. Sharon Moughan**. The practice originated in 1986 and has grown to include five dental hygienists, four dental assistants, one sterilization assistant, and five office administrators.

Our goal is to help you feel and look your best through excellent dental care. Our treatment emphasizes periodontal health as the foundation for excellent dentistry, as we recognize the role periodontal health plays in overall general health. Our services include cosmetic dentistry, including bleaching and veneers, implants, crowns and bridges, periodontal treatment, root canals, Invisalign orthodontics, and children's dentistry.

In case of an emergency
Our office hours are Monday through Thursday, 7:30 A.M. to 5:30 P.M. Should you have an emergency beyond normal office hours, please call the office for emergency information. When the office is closed for vacation, alternate coverage information will be provided.

Appointments and cancellations
Our services are by appointment only. We strive to see all patients on time, and request that you extend the same courtesy to us. A commitment to treatment is essential to ensure the best possible outcome; therefore we ask that you make every effort not to change a scheduled appointment. In order to provide the best service possible, cancellations must be received 48 hours prior to an appointment. Appointments cancelled with less than this notice and any missed appointments will be subject to a $50 fee.

Billing and payment of fees
Full payment or the insurance co-payment is due at the time of treatment. Cash, checks, and credit cards are accepted in addition to extended payment plans through an outside financing company, Care Credit. An estimate of fees and estimated insurance co-payments are available when scheduling. Please call if you have questions or if you need assistance or clarification of our policies.

Our mission is to provide and be recognized
for professional and excellent dental care,
with the highest sense of caring, comfort, and kindness.

I have read the above information and have been informed of the policies above.

Signature ____ Date ____________

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the bottom of the form

☐ 1. WORK TO BE DONE

I understand that I am having the following treatment done:

☐Dental Hygiene(cleaning) ☐Radiographs ☐Root Planing & Scaling ☐Restorations (fillings)

☐Bridges ☐Crowns ☐Extractions

☐Other____

Initials____________

☐ 2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initials__________

☐ 3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, including the possible need for root canal therapy following treatment.

Initials_____

☐ 4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or in rare occasions may be permanent; or fractured jaw.

Initials_____

I have had an opportunity to ask questions about these treatments and other alternatives.

______________________________	______________________________	____________________
Patient Name (Print)	Patient/Legal Guardian Signature	Date

ADDITIONAL WORK TO BE DONE

I understand that I am having the following additional treatment done:

☐Dental Hygiene(cleaning) ☐Radiographs ☐Root Planing & Scaling ☐Restorations (fillings)

☐Bridges ☐Crowns ☐Extractions

☐Other____

Initials____________ Date_________________

Associates in Dental Health

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

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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ADH
ASSOCIATES IN
DENTAL HEALTH

WELCOME!

Thank you for selecting our office for your care. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form *completely*, both sides. If you need any assistance, please ask. We will be happy to help.

PERSONAL INFORMATION

Patient Name: ____ Date:__________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other____________________

Social Security #: ________________________ Birth Date:________________________

Phone (H) ____________________ (W) ____________________ (Cell) ____________________

Email ____

Address: ____
Street Apartment # PO Box

____
City State Zip Code

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Website ☐ Insurance ☐ School ☐ Work ☐ Other__________________

Name of person or office referring you to our practice:____

PARENTAL INFORMATION

The following is for: ☐ the patient's father ☐ the patient's mother ☐ the patient's guardian

Parent/Guardian Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____________________________

Social Security #: ________________________ Birth Date: ________________________

Phone (H) _________________ (W) _________________ (Cell) _________________ Email ______________________

Address: ____
Street Apartment #

____
City State Zip Code

The person accompanying the child is responsible for all payments and co-payments at the time of the visit.

FINANCIAL INFORMATION

All emergency dental services, insurance co-payments, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

For your convenience we offer the following methods of payment. Please check the option you prefer:

Cash ☐ Personal Check ☐ Credit Card: MC ☐ Visa ☐ Discover ☐

Please Complete Other Side

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the patient's father ☐ the patient's mother ☐ the patient's guardian

Employer Name: ____________________ Occupation: ____________________

Address: ____
Street City State Zip Code

PRIMARY INSURANCE INFORMATION

Name of Subscriber: ____________________ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: ____________ Subscriber's Social Security #: ____________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ____

Employer Address: ____
Street City State Zip Code

Insurance Group #: ____________________

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other____________

Insurance Plan Name: ____________________ Plan Telephone #: ( ) ____________

Insurance Plan Address: ____
Street City State Zip Code

Do you have a secondary dental insurance? ☐ No ☐ Yes, ____________________
Insurance Plan Name

Please provide your insurance cards so we may make a copy for your file.

CONSENT FOR SERVICES

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I authorize the dentist to release any information regarding treatment rendered to me or my child to third party payers and/or other health professionals.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within fourteen (14) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

____________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

Thank you for filling out this form completely.