DENTIST OF CHESTER SPRINGS
FAMILY DENTISTRY

PATIENT INFORMATION

We would like to get to know you better!

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your response to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

First Name | MI | Last Name | Phone | Cell

Address | Apt # | City | State | Zip

SS # | DOB | Marital Status: ( ) *Married* ( ) *Divorced* ( ) *Single* | Email

Gender :
( ) Male ( ) Female ( ) Other

If you are completing this form for another person what is your Name and relationship to this person:

Primary Dental Insurance Carrier | Insurance Phone Number

Emergency Contact Name | Emergency Contact Relationship ( ) *Parents* ( ) *Spouse* ( ) *Other* | Emergency Contact Phone Number

Subscriber's Name | Subscriber's Date of Birth | Subscriber ID # | Patient's Relationship to Subscriber: ( ) *Self* ( ) *Spouse* ( ) *Child*

Subscriber's Employer | Work Phone | Group Number

How did you hear about Dentist of Chester Springs ?

What is the best way we can contact you? Please check one choice for each category.

Preferred Contact Method: ( ) *Home Phone* ( ) *Cell Phone* ( ) *Work Phone* ( ) *Text Messages* ( ) *Email*

Preferred Confirmation Method: ( ) *Home Phone* ( ) *Cell Phone* ( ) *Work Phone* ( ) *Text Messages* ( ) *Email*

Preferred Recall Method: ( ) *Home Phone* ( ) *Cell Phone* ( ) *Work Phone* ( ) *Text Messages* ( ) *Email*

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HEALTH HISTORY

First Name | Last Name | DOB

Dental Information: For the following questions, please check Yes or No to your responses.

Do your gums bleed when you brush or floss? ( ) Yes ( ) No

Are your teeth sensitive to cold, hot, sweets or pressure? ( ) Yes ( ) No

Does food or floss catch between your teeth? ( ) Yes ( ) No

Is your mouth dry? ( ) Yes ( ) No

Do you have an unpleasant taste or odor? ( ) Yes ( ) No

Do you smoke or use Tobacco products? ( ) Yes ( ) No

How many times a day do you brush your teeth? _____

Floss? _____

Have you ever had any problems associated with previous dental treatment? ( ) Yes ( ) No

Has the fear of discomfort kept you from regular dental visits? ( ) Yes ( ) No

Are you currently experiencing dental pain or discomfort? ( ) Yes ( ) *No*

When was your last dental Appointment _____

How long has it been since last complete examination with a full series of x-rays? _____

How do you feel about your smile?

_____

What prompted you to seek dental care at his time?

What makes you unhappy about your smile?

Are you interested in teeth whitening?

Are you interested in straightening your teeth?

Are you concerned with the cost of maintaining your oral health?

What are the challenges you face in maintaining good oral health?

Do you have earaches or neck pains? ( ) *Yes* ( ) *No*

Do you have any clicking, popping or discomfort in the jaw? ( ) *Yes* ( ) *No*

Do you grind your teeth? ( ) *Yes* ( ) *No*

Do you have any sores or ulcers in your mouth? ( ) *Yes* ( ) *No*

Do you wear dentures or partials? ( ) *Yes* ( ) *No*

Have you ever had a serious injury to your head or mouth? ( ) *Yes* ( ) *No*

Medical Information:

Are you currently under the care of a physician? If Yes, reason: ( ) *Yes* ( ) *No*

Physician Name: _____

Phone: _____

Address:

Are you in good health? ( ) *Yes* ( ) *No*

Has there been any change in your general health within the past year? ( ) *Yes* ( ) *No*

If Yes, Explain: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ( ) *Yes* ( ) *No*

If Yes, Explain: _____

Date of last physical exam? _____

Have you had any Orthopedic Joint Replacements? ( )*Yes* ( ) *No*

(Hip, Knee, Finger, Etc.)

If Yes, Explain: _____

Please List all Medication You Are Taking:

Do You have any Drug Allergies?	( ) *Yes* ( ) *No*	Sulfa Drugs	( ) *Yes* ( ) *No*
Local Anesthetics	( ) *Yes* ( ) *No*	Codeine or Other Narcotics	( ) *Yes* ( ) *No*
Aspirin	( ) *Yes* ( ) *No*	Latex (rubber)	( ) *Yes* ( ) *No*
Penicillin or other Antibiotics	( ) *Yes* ( ) *No*	Iodine	( ) *Yes* ( ) *No*
Barbiturates, Sedatives, or Sleeping Pills	( ) *Yes* ( ) *No*	Hay Fever / Seasonal	( ) *Yes* ( ) *No*
Food	( ) *Yes* ( ) *No*	( ) Other: _____	
Females: Are you currently pregnant?	( ) *Yes* ( ) *No*		

Please indicate if you have or have not had following any of the diseases or problems:		Artificial (prosthetic) Heart valve	( ) *Yes* ( ) *No*
Autoimmune disease	( ) *Yes* ( ) *No*	Previous infective endocarditis	( ) *Yes* ( ) *No*
Rheumatoid Arthritis	( ) *Yes* ( ) *No*	Damage Vales in transplanted heart	( ) *Yes* ( ) *No*
Systemic Lupus Erythematosus	( ) *Yes* ( ) *No*	Congenital Heart Disease (CHD)	( ) *Yes* ( ) *No*
Asthma	( ) *Yes* ( ) *No*	Repaired (completely) in last 6 Months	( ) *Yes* ( ) *No*
Bronchitis	( ) *Yes* ( ) *No*	Unrepaired, cyanotic CHD	( ) *Yes* ( ) *No*
Emphysema	( ) *Yes* ( ) *No*	Gastrointestinal Disease	( ) *Yes* ( ) *No*
Sinus Trouble	( ) *Yes* ( ) *No*	G. E. Reflux/Persistent Heartburn	( ) *Yes* ( ) *No*
Tuberculosis	( ) *Yes* ( ) *No*	Ulcers	( ) *Yes* ( ) *No*
Cancer / Chemotherapy	( ) *Yes* ( ) *No*	Thyroid Problems	( ) *Yes* ( ) *No*
Radiation Treatment	( ) *Yes* ( ) *No*	Stroke	( ) *Yes* ( ) *No*
Chest Pain upon exertion	( ) *Yes* ( ) *No*	Glaucoma	( ) *Yes* ( ) *No*
Chronic Pain	( ) *Yes* ( ) *No*	Hepatitis, Jaundice or Liver disease	( ) *Yes* ( ) *No*
Diabetes: Type I ( ) or II ( )	( ) *Yes* ( ) *No*	Epilepsy	( ) *Yes* ( ) *No*
Eating Disorder	( ) *Yes* ( ) *No*	Fainting s\Spells or Seizures	( ) *Yes* ( ) *No*
Kidney Problem	( ) *Yes* ( ) *No*	Neurological Disorders	( ) *Yes* ( ) *No*
If Yes, Explain: _____		If Yes, specify: _____	
		Mental Health Disorders	( ) *Yes* ( ) *No*
		If Yes, specify: _____	
Sexually Transmitted Disease	( ) *Yes* ( ) *No*	Severe Headaches / Migraines	( ) *Yes* ( ) *No*
Cardiovascular Disease	( ) *Yes* ( ) *No*	Low Blood Pressure	( ) *Yes* ( ) *No*
Angina	( ) *Yes* ( ) *No*	High Blood Pressure	( ) *Yes* ( ) *No*
Arteriosclerosis	( ) *Yes* ( ) *No*	Other Congenital Heart Defects	( ) *Yes* ( ) *No*
Congestive Heart Failure	( ) *Yes* ( ) *No*	If Yes, Explain: _____	
Damaged Hear Valves	( ) *Yes* ( ) *No*	Arthritis	( ) *Yes* ( ) *No*
Heart Attack	( ) *Yes* ( ) *No*	Mitral Valve Prolapse	( ) *Yes* ( ) *No*
Heart Murmur	( ) *Yes* ( ) *No*	Pacemaker	( ) *Yes* ( ) *No*
Rheumatic Fever	( ) *Yes* ( ) *No*	Abnormal Bleeding	( ) *Yes* ( ) *No*
Anemia	( ) *Yes* ( ) *No*	Blood Transfusion	( ) *Yes* ( ) *No*
AIDS or HIV	( ) *Yes* ( ) *No*	If Yes, Date: _____	
Has a Physician or previous Dentist recommended that you take antibiotics prior to your dental treatment? ( ) *Yes* ( ) *No*		**If Yes, Name of Physician or Dentist making recommendation:** **Phone:**	
Do you have any disease, condition, or problem not listed above that you think should be notated or discussed?			

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: **Date:**

Comments By Dentist:

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CONSENT FOR SERVICES

Patient's Name: _____ DOB: _____
First Last

As a condition of your treatment by this office, financial arrangements must be made in advance.
All co-payments are due at the time services are rendered.

Any emergency and/or after hours dental services are subject to additional fees.

Patients who carry dental insurance understand that payment for all services furnished are ultimately their responsibility. Insurance does not guarantee payment and we cannot receive any guarantee of payment. This office cannot render services on the assumption that our charges will be paid by an insurance company. As a courtesy to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. Any such collections will be credited to the patient's account and any resulting balance is the patient responsibility.

In this office we believe in providing our patients with the highest standard of care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however it is not standard of care today and we do not recommend the use of them.

X-rays and Photographs:

I authorize Smile Dentist of Chester Springs(DOCS), the doctor and team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPAA regulations).

Appointment Policy:
If you find it impossible to keep an appointment, for consideration of other patient's needs, we ask for **48-hour** notice, please.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for services at the time they are rendered or within **5 days** of billing, if credit is extended at the discretion of the practice. Outstanding balances may be subject to additional charges. I further agree to pay all costs and reasonable attorney fees if my account has to be turned over to a third-party collection agency.

By **checking here ( ) and signing below**, I acknowledge that I have read and agree to the above terms of treatment.

X _____ Date: _____
(Signature of Patient or Responsible Party*)
*Responsible Party - Relationship to Patient: _____

Thank you for choosing **Dentist Of Chester Springs** as your dental provider. We are committed to providing you with the highest quality dental care using only the best material and technology available on the market today. We are also committed to providing you with up to date information and educational tools so that you may fully participate in your oral health care decisions.

Please understand that payment of your bill is part of this treatment and care. Any unpaid insurance balance older than 30 days is the patient's responsibility. Uninsured patients are expected to pay in full, at the time of service.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information regarding these policies, please ask to speak with the office manager.

Q&A:

What Forms of Payment are Accepted?

We accept cash, personal check, VISA, MasterCard, AMEX, Discover, Care Credit and Enhanced Patient Financing.

Which Insurance Plans Do You Contract With?

Dentist Of Chester Springs(DOCS) accepts most major PPO dental insurance plans. Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims. It is your responsibility to verify that the facility is in network and a participating provider with your plan. A current provider listing should be made available to you by your employer, insurance company or insurance website.

What is My Financial Responsibility for Services Rendered?

You are responsible to make payment in full at the time of service if you are not insured. Our insured patient's are expected to pay their ***estimated*** out of pocket portion at time of service. Your estimated portion may be adjusted after the time of service contingent upon final reconciliation of insurance payments.

What Documents Must I Supply?

Our office requires that you supply a photo ID as well as your insurance card and/or social security number for verification of benefits. You are further required to update our office in a timely fashion of any changes to your personal information including but not limited to, name change, mailing address, insured party change (guarantor), loss of or change in employment or change in insurance coverage.

What are My Options for Financial Assistance if I Do Not Have Dental Insurance?

Our office is proud to offer a **Patient DOCS Loyalty Plan**! This plan is exclusive to Dentist Of Chester Springs(DOCS) and is not insurance coverage. It is designed to provide you with the opportunity to maintain your oral health without the worries and stress of overwhelming financial burdens. This plan covers two free exams, cleanings and x-rays annually, as well as discounted pricing on most our services. Please ask one of our team members for more information on how this option might benefit you!

Additional Information…

Our office does not use amalgam (silver in color) for restorations. We understand that patients want and prefer tooth-colored fillings. Most insurance companies “down grade” this service; your estimated out of pocket for fillings may differ from what was paid upfront. Any amounts passed on to you by your insurance, that was not collected at the time of service, will be billed to you by mail.

Our office makes the best effort to guide you through the insurance billing and collection process. Unfortunately, it is unreasonable to expect that we will know all the details for every employer plan.

Non-Payment on Account-An account with an unpaid balance is subject to third party collection agency intervention. Should such an event be required, you will be charged an additional $50.00 collection fee. Dentist Of Chester Springs(DOCS) has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. If your account is referred to a collection agency, attorney or court, the past due status may be reported to credit reporting agencies and could have an adverse effect on your credit history. Failure to comply with our financial policies may also result in withdrawal of care.

Returned Check-An account with a returned check (bounced) will have an additional $50.00 fee added to the balance.

I have read and fully understand my financial obligations.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Printed Name Relationship to Patient

( ) -

_____ _____

Mailing Address Phone

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

By checking here ( ) and sign below, I acknowledge that I have received a copy of this office's notice of Privacy Practices.

Patient's Name : _____ DOB :_____
First Name Last Name

Signature of Patient/Legal Guardian **Date:**

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I, authorize the following person(s) to have access to information covered user the Privacy Practice regarding myself.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknowledging

( ) An emergency situation prevented us from obtaining acknowledger

( ) Other (Please Specify) _____