Welcome

Thank you for selecting our dental health team.
We look forward to working with you in maintaining your dental health.

Date ____/____/____

Patient's Name _____
Last First M.I.
Address _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____
Cell Phone (____) _____ Email address _____

Preferred Contact Method:
□ Home □ Work □ Cell □ Text Message □ Email

Date of Birth ____/____/____ Social Security # _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact _____ Phone Number (____) _____

Preferred Contact Method:
□ Home □ Work □ Cell □ Text Message □ Email

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION
Primary:

Name of Insurance _____
Group Number _____Name of Subscriber _____
Name of Employer _____
Subscriber's Social Security # _____-_____-_____
Subscriber's Date of Birth ____/____/____

Secondary:

Name of Insurance _____
Group Number _____Name of Subscriber _____
Name of Employer _____
Subscriber's Social Security # _____-_____-_____
Subscriber's Date of Birth ____/____/____

Silvers Family Dental Care, LLC 4392 Sturbridge Drive Harrisburg, PA 17110 Office (717) 564-1681 Fax (717) 754-0827

Financial Policy

We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, Discover or American Express. Care Credit may also be available to you.

Your insurance policy is a contract between you and your insurance company. Your insurance coverage, and benefits is your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

Any deductible or estimated co-payment amount will be due at the time of treatment.

If payment for services already rendered has not been paid in full within 90 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

A 20% collection fee will be added to any unpaid balance past due over 90 days for which a payment plan has not been established and maintained. If no response is received after 90 days and a delinquency letter, the account may be turned over to collection service and reported to the credit reporting bureaus.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if opening arise. **We reserve the right to charge and collect $60.00 for any broken appointments**. Broken appointments are considered those that are missed (no-show) and cancelled with less than 48 business hour advance notice.

I have read and understand this financial policy.

Patient or Parent/Guardian Signature: _____**Date**: ____/____/_____

Patient Name: _____

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Late Arrival, Cancellation and Missed Appointment Policy

Our office is dedicated to providing all of our patients with the most thorough and comfortable dental care available. We know that efficient scheduling is an important part of the dental office experience.

1. **On Time Arrival**
   Please arrive a few minutes before your scheduled appointment time

2. **Late Arrival**
   We respect our patients' time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could delay us. If we are significantly delayed, every effort will be made to notify you beforehand. In turn, if you are running late, we ask that you please notify us. If you are significantly delayed, your scheduled treatment may be modified or you may be asked to reschedule your appointment.

3. **Cancellation**
   We do require a 48 business hour notice for all changes to scheduled appointments. If 48 business hour notice is not given, we reserve the right to apply a broken appointment fee to your account.

4. **Missed Appointment**
   It is extremely important that all patients honor their dental appointments. Therefore, all patients who fail to arrive for their scheduled appointments will be charged for a broken appointment.

Our broken appointment fee is **$60.00 per appointment**; this fee is subject to change. If a broken appointment fee has been applied to your account, the fee must be paid prior to rescheduling.

Please Note: As a courtesy to you, we will make every effort to remind you of your scheduled appointment. If our attempts are unsuccessful, it is still your responsibility to keep your scheduled appointment or to contact us 48 business hours in advance to change or cancel your appointment.

We feel these guidelines are reasonable in relation to the services we provide. We understand that circumstances occur that will require our consideration. Any questions are always welcome.

I, the undersigned, understand and agree to the late arrival, cancellation and missed appointment policy.

Patient or Parent/Guardian Signature: _____ Date: ___/___/_____

Patient Name: _____

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Medical History

1. Are you in good health? □ Yes □ No

   If no, please explain_____

2. Name of your primary care physician _____

   Address _____ Phone _____

3. Last exam date with your primary care physician ____/____/____

4. Are you under a physician's care now? □ Yes □ No

   If yes, please give reason for treatment _____

5. Female Patients: □ Y □ N Currently nursing? □ Y □ N Currently pregnant? Due Date: ____/____/____

6. Is pre-medication required before dental visits due to heart condition or artificial joint? □ Y □ N

7. Do you have any trouble with prolonged bleeding? _____

8. Do you smoke or use smokeless tobacco? □ Yes □ No If yes, how much? _____

9. Do you have, or have you ever had any of the following? (Check yes or no):

□ None

□ Yes □ No Acid Reflux	□ Yes □ No Chemical Dependency	□ Yes □ No Kidney Disease
□ Yes □ No ADHD	□ Yes □ No Convulsions	□ Yes □ No Liver Problems
□ Yes □ No AIDS/HIV	□ Yes □ No Depression	□ Yes □ No Mitral Valve Prolapse
□ Yes □ No Anemia	□ Yes □ No Diabetes	□ Yes □ No Mononucleosis
□ Yes □ No Anorexia	□ Yes □ No Dizziness/Fainting	□ Yes □ No Pacemaker
□ Yes □ No Anxiety	□ Yes □ No Epilepsy/Seizures	□ Yes □ No Psychiatric Treatment
□ Yes □ No Artificial Heart Valve	□ Yes □ No Frequent Ear Infections	□ Yes □ No Radiation/Chemo
□ Yes □ No Artificial Joints	□ Yes □ No Frequent Headaches	□ Yes □ No Respiratory Disease
□ Yes □ No Arthritis	□ Yes □ No Hearing Problems	□ Yes □ No Rheumatic Fever
□ Yes □ No Asthma	□ Yes □ No Heart Attack	□ Yes □ No Sinus Problems
□ Yes □ No Autism/Asperger's	□ Yes □ No Heart Disease	□ Yes □ No Stroke
□ Yes □ No Bleeding Disorder	□ Yes □ No Heart Murmur	□ Yes □ No Thyroid Condition
□ Yes □ No Bulimia	□ Yes □ No Hepatitis	□ Yes □ No Tuberculosis
□ Yes □ No Cancer/Malignancy	□ Yes □ No High Blood Pressure	□ Yes □ No Ulcers
□ Yes □ No Cerebral Palsy	□ Yes □ No High Cholesterol	□ Yes □ No Venereal Disease/STDs

□ Other _____

_____

Patient Name: _____

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Medical History Continued

10. Do you have any condition not listed above that you think we should know about? □ Yes □ No

If yes, please explain _____

11. Are you ALLERGIC to or have you ever had any reaction to the following? (Check yes or no):

□ None

□ Yes □ No Aspirin
□ Yes □ No Anesthetic- Local
□ Yes □ No Barbiturates
□ Yes □ No Codeine
□ Yes □ No Lactose Intolerant
□ Yes □ No Latex
□ Yes □ No Metal Sensitivity
□ Yes □ No Nuts
□ Yes □ No Nitrous Oxide Sedation
□ Yes □ No Sleeping Pills
□ Yes □ No Sulfa Drugs
□ Yes □ No Penicillin
□ Yes □ No Other Antibiotics

□ Other – please list _____

_____

12. Are you currently taking any of the following? (Check yes or no):

□ None

□ Yes □ No Antibiotics/Sulfa Drugs
□ Yes □ No Antihistamines/Allergy
□ Yes □ No Blood Pressure Medications
□ Yes □ No Blood Thinners
□ Yes □ No Cancer/Chemo Medications
□ Yes □ No Cholesterol Medications
□ Yes □ No Cortisone/Steroids
□ Yes □ No Daily Aspirin
□ Yes □ No Heart Medication/Digitalis
□ Yes □ No Insulin
□ Yes □ No Nitroglycerin
□ Yes □ No Oral Contraceptives
□ Yes □ No Recreational Drugs
□ Yes □ No Thyroid Medications

□ Please list all medications that you are currently taking _____

_____

_____

I, the undersigned, do affirm that the above information is correct and do give consent to agreed upon dental service, and use of appropriate methods thereto.

Patient or Parent/Guardian Signature: _____ **Date**: ____/____/____

Patient Name: _____

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Dental Health

1. Name of previous dentist _____

   Address _____ Phone _____
2. When was your last dental visit? ____/____/____
3. What is your dental preference?

   □ Local Anesthetic □ No anesthetic □ Relative Analgesia (Nitrous Oxide)

   □ Oral Pre-Medication □ I.V. Sedation
4. Have you ever had any unfavorable reaction from previous medical or dental care? □ Yes □ No

   If yes, please explain _____
5. Are you pleased with the appearance of your teeth? □ Yes □ No

   If no, why? _____
6. Do you have sore or sensitive teeth? □ Yes □ No

   If so, is it to: □ Sweets □ Hot □ Cold
7. Do you think you have bad breath? □ Yes □ No
8. Have you ever had orthodontic (braces) treatment? □ Yes □ No
9. Do you grind or clench your teeth during the day or night? □ Yes □ No
10. Have you ever had treatment for gum disease? □ Yes □ No
11. Have you ever had teeth become loose on their own without injury? □ Yes □ No

    If yes, please explain _____
12. Do your gums bleed? □ Yes □ No

    If yes, please explain _____
13. Do you have pain or anywhere else in your face or jaws? □ Yes □ No

    If yes, where? _____

I, the undersigned, do affirm that the above information is correct and do give consent to agreed upon dental service, and use of appropriate methods thereto.

Patient or Parent/Guardian Signature: _____ **Date**: ____/____/____

Patient Name: _____

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Silvers Family Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

By signing this form you are stating that you have received a copy of this office's Notice of Privacy Practices.

_____

Patient's Name (Please Print)

_____

Patient or Parent/Guardian Signature

_____

Date

For Office Use Only

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

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify) _____

Patient Name: _____