

Welcome to Silvers Family Dental Care

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.

Preferred Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email address _____

Preferred Contact Methods:

Home Work Cell Text Message Email

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

Marital Status: Single Married Divorced Widowed

Emergency Contact _____ Phone Number (____) _____

Preferred Pharmacy _____ Pharmacy Phone (____) _____

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

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:

Name of Insurance _____

Claim Address _____

Group Number _____ Name of Subscriber _____

Subscriber ID # _____

Subscriber's Social Security # ____-____-____ Subscriber's Date of Birth ____/____/____

Secondary Dental Insurance:

Name of Insurance _____

Claim Address _____

Group Number _____ Name of Subscriber _____

Subscriber ID # _____

Subscriber's Social Security # ____-____-____ Subscriber's Date of Birth ____/____/____

Medical History

1. Are you in good health? Yes No

If no, please explain _____

2. Name of your primary care physician _____

3. Address _____ Phone (____) _____

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

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

If yes, please give reason for treatment _____

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

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

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

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

10. 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 _____

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

If yes, please explain _____

Medical History Continued

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

Other- please list _____

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

- None
- Yes No Antibiotics/Sulfa Drugs Yes No Daily Aspirin
- Yes No Antihistamines/Allergy Yes No Heart Medication/Digitalis
- Yes No Blood Pressure Medications Yes No Insulin
- Yes No Blood Thinners Yes No Nitroglycerin
- Yes No Cancer/Chemo Medications Yes No Oral Contraceptives
- Yes No Cholesterol Medications Yes No Recreational Drugs
- Yes No Cortisone/Steroids 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:** ____/____/____

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:** ____/____/____

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.

There is a **\$50.00 charge** for returned checks.

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:** ____/____/____

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:** ____/____/____

AUTHORIZATION FOR RELEASE OF INFORMATION

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Silvers Family Dental Care, on my behalf regarding (please check all items authorized).

Name of authorized person: _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

Name of authorized person: _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

Name of authorized person: _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

Name of authorized person: _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Silvers Family Dental Care

4392 Sturbridge Drive, Suite 100

Harrisburg, PA 17110

(717) 564-1681

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

I hereby acknowledge that I received a copy of the 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) _____