# WELCOME

**The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.**

## 1 About You

Today's Date: _____

E-mail Address: _____

**Name:** _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: __/__/__ Age:_____ SS #: _____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

**Employer:** _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

## 2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: __/__/__ Driver's License #: _____

**Person Responsible for Account:** _____

Wk #: (____)_____ Ext: ____ Hm #: (____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

## 3 Insurance Coverage

### Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

### Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

**In the event of an emergency, is there someone who lives near you that we should contact?**

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

## 4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

**CONTINUED ON BACK**

## 4 MEDICAL HISTORY *continued*

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

**For Women:** Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

**Have you ever had any of the following diseases or medical problems?**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Hepatitis |
| Y | N | Alcohol / Drug Abuse | Y | N | Herpes / Fever Blisters |
| Y | N | Anemia | Y | N | High Blood Pressure |
| Y | N | Arthritis | Y | N | HIV+ / AIDS |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Hospitalized for Any Reason |
| Y | N | Asthma | Y | N | Kidney Problems |
| Y | N | Blood Transfusion | Y | N | Liver Disease |
| Y | N | Cancer /Chemotherapy | Y | N | Low Blood Pressure |
| Y | N | Colitis | Y | N | Mitral Valve Prolapse |
| Y | N | Congenital Heart Defect | Y | N | Pacemaker |
| Y | N | Diabetes | Y | N | Psychiatric Treatment |
| Y | N | Difficulty Breathing | Y | N | Radiation Treatment |
| Y | N | Emphysema | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Epilepsy | Y | N | Seizures |
| Y | N | Fainting Spells | Y | N | Shingles |
| Y | N | Frequent Headaches | Y | N | Sickle Cell Disease / Traits |
| Y | N | Glaucoma | Y | N | Sinus Problems |
| Y | N | Hay Fever | Y | N | Stroke |
| Y | N | Heart Attack | Y | N | Thyroid Problems |
| Y | N | Heart Murmur | Y | N | Tuberculosis (TB) |
| Y | N | Heart Surgery | Y | N | Ulcers |
| Y | N | Hemophilia | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

_____

_____

**Are you allergic to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Metals |
| Y | N | Codeine | Y | N | Jewelry | Y | N | Penicillin |
| Y | N | Dental Anesthetics | Y | N | Latex | Y | N | Tetracycline |

Please list any other drugs/materials that you are allergic to: _____

_____

## 5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter **teeth?** ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

## I

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

**Signature** **Date**

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

## !

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

**Signature** **Date**

**Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. **Initials:** _____ **Date:** _____

**Doctor's Comments:** _____

_____

### MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____

# ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE REGARDING PRIVACY PRACTICES

*You may waive signature of this acknowledgement*

I, _____, have received a copy of Abington Center for Cosmetic Dentistry' notice regarding privacy practices.

_____
Print Name

_____
Signature

_____
Date

***FOR OFFICE USE ONLY***

The office of Dr. Charles W. Dennis attempted to obtain written acknowledgement for receipt of our notice regarding Privacy Practices, from the above without success, because:

- ◊ Patient refused to sign
- ◊ Communication barriers prohibited obtaining acknowledgement
- ◊ Emergency situation prevented us from obtaining acknowledgement
- ◊ Other (specify): _____

_____

_____

This form does not constitute legal advice, and only covers federal, not state, law in effect as of August 14, 2002. Subsequent law changes may require form verification.

116 North State St.
Clarks Summit
Pennsylvania 18411
p: (570) 587-4031

Member ADA, PDA, AGD
AMERICAN ACADEMY OF COSMETIC DENTISTRY

# Photograph and X-Ray Release Form

I, _____, hereby authorize Dr. Charles W. Dennis and/or
(Print name)
any of his staff to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phonebooks, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:
_____ I give consent to my first name, face, and teeth being used in any of the above stated situations.

Exceptions:
_____ I do not wish to have my First Name shown, or released.
_____ I do not wish to have my face shown.
_____ I only agree to have my teeth shown without any identifying features.
_____ I do not wish to have my photos used at all.

_____ _____
Print Name Date

_____
Signature

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We would like to thank you for entrusting us with your dental care. We pride ourselves in providing our patients with the highest standard of care paired with the best available technology. Abington Center's staff is amongst the best trained in the profession, and constantly strives to provide care with the utmost empathy and compassion. Your unwavering confidence is our goal. This document will help address some misconceptions and alleviate potential misunderstandings.

## Insurance

Our office provides the best care and treatments for our patients. We will never recommend care based on insurance fees or contracts. Your treatment plan is solely base on your dental needs. We participate with a wide variety of insurance plans, but please inquire if we accept yours to avoid billing issues later. As a courtesy to our patients, we **estimate** your co-pays for you. Unfortunately, dental insurance does not cover all dental care Most policies have limits and/or various degrees of co-payment. **The total portion that is not covered by your insurance is to be paid at the time services are rendered.** Our staff will be glad to assist you with any questions pertaining to your insurance.

## Missed Appointments and Cancellations

In order to give you the best quality of care and undivided attention, our office does not double book appointments. In today's busy world, we understand there are unforeseen emergencies that may force you to cancel your appointments. We ask that you call our office at least **48 hours** prior to your appointment. **To cancel or reschedule an appointment, you MUST speak to one of our office staff. Do NOT leave a message.**
Our office will charge $50.00 to the account of any patient who fails or cancels an appointment without proper notification. This is strictly enforced so that each patient can receive the best quality of care.

## Administrative Fees (If Applicable)

Our office will do our best to work with you should a financial issue arise. However, if a collections and/or legal service is required,to obtain a payment, I agree to pay for all fees and costs incurred.
Returned checks are subject to a $30 fee.

## Payment Options

We understand that it is important to offer convenience to our patients. Therefore, we offer and accept a variety of payment options, including:

- Cash
- Personal Check
- Debit or Credit Cards (Including Visa, Mastercard, American Express, etc)
- CareCredit: Offers patients a financing option to cover your or your family's medical and dental care needs. In most situations, this is an **interest-free** program for up to 24 months. This program is most helpful for allowing you to being necessary treatment sooner while spreading the cost over a period of time. Please inquire with our office staff to attain further information regarding this option.

*If you have any questions, please feel free to inquire before signing below.*

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I understand and agree that regardless of insurance (if applicable) I am ultimately responsible for the balance on my account for all charges and services rendered. I have read and understand all of the information on this sheet.

Print Name _____ Signature _____

Date _____

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