4940 Linglestown Road
Harrisburg, PA 17112
Phone 717-901-7045
Fax 717-657-2712

NAME _____
LAST FIRST M

Married □ **Single** □ **Minor** □ **Male** □ **Female** □ **SS#** _____

ADDRESS _____
STREET APT.# CITY ST ZIP

BIRTHDATE _____ **TELEPHONE** _____
MO DAY YR HOME CELL WORK

EMAIL ADDRESS _____

NAME OF EMPLOYER _____

PERSON RESPONSIBLE FOR ACCOUNT □ SELF □ GUARDIAN □ SPOUSE □ FATHER □ MOTHER

INSURANCE INFORMATION

PRIMARY INSURED / If no insurance complete for responsible party

_____
LAST FIRST M

_____
STREET CITY ST ZIP

_____
HOME CELL WORK

_____
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INS. CO.

_____
SS# SUBSCRIBER # GROUP#

SECONDARY INSURED

_____
LAST FIRST M

_____
STREET CITY ST ZIP

_____
HOME CELL WORK

_____
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INS. CO.

_____
SS# SUBSCRIBER # GROUP#

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

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____
Relationship to patient: _____
City, State: _____
Telephone: _____

ASSIGNMENT OF BENEFITS AGREEMENT FOR COLONIAL DENTAL GROUP

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.

- Insurance payments ordinarily are received within 15 days from the time of billing. If your insurance company has not made payment to our practice within 30 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied you will be responsible for paying the full amount at that time.

- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort our any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

BROKEN APPOINTMENT POLICY: Your appointment time is reserved exclusively for you. We realize that unforeseen circumstances befall us all. However, we do require **24 hours notice** to avoid a broken appointment charge. Although the office does attempt to make **courtesy** calls regarding your appointments, we consider these appointments to be **your responsibility**.

Broken Appointment Charge is $75 Initial _____

SERVICE CHARGE: If I do not pay the entire new balance within **60 days** of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of **1.5%** per month. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. **Initial _____**

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE AVOBE POLICIES. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

Signature of Patient or Responsible Party **Date** **Witness**

_____

PATIENT NAME

Dental History

1. Do you have a specific dental problem? Describe: _____

_____

2. Do you have dental exams on a regular basis and when was you last visit? _____

3. Do you think you have active decay or gum disease? _____

4. Do you brush and floss on a regular basis? _____

5. Do your gums ever bleed? _____

6. Do you like your smile? _____

7. Does food catch between your teeth? _____

8. Do you want to keep your remaining teeth? _____

9. Do you ever have clicking, popping or discomfort in the jaw joint? _____

10. Do you clench or grind your teeth? _____

11. Have your experiences with dentists in the past been positive? _____

12. Do you smoke or chew tobacco or its products? _____

13. Are there any sores or growths in your mouth? _____

14. Name of previous dentist (optional) _____

15. Date of last full mouth x-rays (18 small films or panoramic): _____

Medical History:

1. Are you under a physician's care now and why? _____

2. Dr's. Name and Phone : _____

3. Have you ever been hospitalized or had a major operation? _____

4. Have you ever had a serious injury to your head or neck? _____

5. **Are you taking any of the following medication? Please list**.

□Yes □ No Antibiotics _____

□Yes □ No Anticoagulants (Blood thinners) _____

□Yes □ No Aspirin or drugs like Motrin, Ibuprofen or Aleve _____

□Yes □ No Have you ever taken (please circle) Bisphosphonates (for osteoporosis, multiple myeloma or other cancers), Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, or Prolia

□Yes □ No Chemotherapy for any cancers: _____

□Yes □ No Steroids (Cortisone or Prednisone): _____

6. Please list any other medications you may be taking: _____

_____

_____

Allergies:

Are you allergic to any of the following, please circle below:

Local anesthetic (Novocain) Aspirin or NSIADs Penicillin or any other antibiotics

Codeine Acrylic Metal Latex Milk or food products

Others please list:

_____

For Women only: Please Circle.

Pregnant or trying to get pregnant Nursing Taking oral contraceptive

Do you or have you ever had any of the following conditions:

1. **HEART: (High Blood Pressure, Heart Murmur, Coronary Artery Disease, Stroke, Pacemaker, Palpitations, Endocarditis, Congenital Heart Disease or Stents).** **Yes □ No □**
2. **ARTIFICIAL Heart Valves, Artificial Joints, Pins, or Plates (hip, knee, shoulders, etc)** **Yes □ No □**
3. **Do you know if you need to PREMED with antibiotics?** **Yes □ No □**
4. **LUNG: (Asthma, Emphysema, COPD, Bronchitis, Pneumonia, Chronic cough)** **Yes □ No □**
5. **LIVER: (Jaundice, Hepatitis A/B/C/)** **Yes □ No □**
6. **CANCER or History of ANY Cancer** **Yes □ No □**
7. **ANY DISEASE, DRUG or TRANSPLANT operation that has depressed your immune system?** **Yes □ No □**
8. **Is there any past history of Emotional Disorder or Psychiatric care? Yes □ No □**
9. **Is there any past history of Alcohol or Chemical Dependency? Yes □ No □**
10. **Have you ever had any other serious illness not checked above? Discuss.**

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11. **Do you wish to talk to the dentist privately about any problem** **Yes □ No □**
12. **Answer following by checking appropriate boxes.**

	Yes	No		Yes	No
Anemia	☐	☐	**AIDS/ HIV**	☐	☐
Alzheimer's Disease	☐	☐	**Anxiety/ Depression**	☐	☐
Arthritis/Rheumatism/ Gout	☐	☐	**Blood Transfusions**	☐	☐
Bleeding Disorders (Hemophilia etc)	☐	☐	**Diabetes Type 1 (Insulin Dependent)**	☐	☐
Diabetes Type 2 (Non Insulin Dependent)	☐	☐	**Dialysis**	☐	☐
Epilepsy/ Seizures	☐	☐	**Fainting/ Dizziness**	☐	☐
Herpes/ Cold sores	☐	☐	**Leukemia**	☐	☐
Pain in jaw joints	☐	☐	**Osteoporosis**	☐	☐
Radiation therapy	☐	☐	**Sinus Trouble**	☐	☐
Swelling of limbs	☐	☐	**Thyroid Disease**	☐	☐
Tuberculosis	☐	☐			

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health or medicine change, I shall inform the dentist and staff at the next appointment without fail.

X_____ **Date** _____

Patient Signature (Parent or Guardian)

Reviewed By Doctor _____ **Date** _____