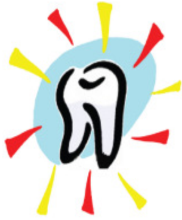
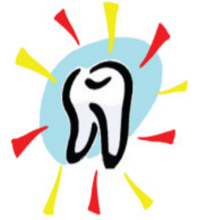


PLYMOUTH VALLEY DENTAL GROUP
WWW.PLYMOUTHVALLEYDENTAL.COM

ROBERT L ADELMAN, DMD
ADELMANDMD@VERIZON.NET
832 GERMANTOWN PIKE, SUITE #1
PLYMOUTH MEETING PA 19462-2442



OFFICE: (610) 277-0996
FAX: (610) 275-5075

We would like to welcome you to our practice today. Since you may have been away from us for a while, we ask you to kindly read, fill out and sign the forms attached. We take pride in keeping our records as current as possible. This enables us to better serve your dental needs. If you should have any questions please ask them when you bring these forms to the front desk personnel.

Sincerely,

Robert Adelman, DMD and staff

PLEASE PROVIDE US WITH YOUR UPDATE CONTACT AND INSURANCE INFORMATION

Name: ______________________ Date: ______________

Address: ______________________

City: __________ State: __________ Zip: __________

Email: ______________________

Home Phone: ______________ Work Phone: ______________

Cell Phone: ______________________

Subscriber's Employer: ______________________

Dental Insurance Carrier: ______________________

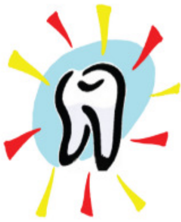
Dental insurance Carrier Address and Phone Number: ______________________

____

____

Subscriber's Social Security Number: ______________________

Group Number: ______________________



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Financial Policy Changes Starting November 1st, 2010

We are committed to providing you with the best possible care. To help us maintain billing costs to a minimum, we have implemented the following financial policy. If you have any questions, please do not hesitate to ask us.

PAYMENT IS DUE AT THE TIME OF SERVICE

Please understand that payment of your bill is considered a part of your treatment. Patients with PREAUTHORIZED work are asked to pay their CoPay at the time of service. Patients without a Preauthorization are asked to pay an estimated amount based on your percentage of the UCR [Usual and Customary Rate for the area] covered under the terms in your dental insurance. Since we are familiar with the UCR for our office, we will strive to give you the most accurate estimate. If overpayment occurs, a refund will be mailed to you.

Minor patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. Once your child turns 18 years of age, you MUST inform us IN WRITING if you are no longer financially responsible for them. Otherwise, you will be responsible for services provided to them regardless of whether you accompanied them.

- We accept cash, checks, MASTERCARD/VISA/DISCOVER and DEBIT
- We accept Paypal via ***Adelmandmd@plymouthvalleydental.com*** and also ***Citi Healthcard***.
- Returned checks will be subject to additional collection fees and charges.

Patients with dental insurance: We will continue to submit to your insurance company. However, we ask that you pay your insurance co-payment for Major services at the time of treatment. Deductibles may or may not apply in addition to co-payments. Co-payments vary depending upon individual policies of your plan. Typical co-payment requirement: 50%-60% of the UCR, plus any deductible.

Patients without dental insurance will receive a 5% discount for services in excess of $500.00 when paid in full at the time of treatment.

Patients enrolled in our Plymouth Valley Dental Group plan MUST pay their copayment on the date of service, and MUST renew the plan each year as of their anniversary date in order to continue to be enrolled in our plan.

SPECIAL INFORMATION FOR PATIENTS WITH INSURANCE:

We will gladly discuss any questions relating to your insurance. However, please realize that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our fees generally fall within the acceptable range in our area of service. Being a participating dentist means we accept as payment in full the UCR amount set by the insurance company. Your employer contracts with your insurance company to design your benefits. Not all services are a covered benefit in all contracts. If we provide a service that is not a covered benefit under your plan, you will be responsible for payment in full of our usual fees.
- As dental care providers, our relationship is with ***YOU***, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all rendered charges are your responsibility from the date of service. Any disputes regarding your coverage must be handled between you and your insurance company. There will be a $50.00 charge if we have to resubmit claims because you did not provide us with your current and correct insurance information.

Signature of Responsible Party:________________________________ Date:__________

MEDICAL AND DENTAL INFORMATION PAGE 1 OF 2

Date:

If you are completing this form for another person, what is your relationship to that person? ____________________
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses 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.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐	☐

If yes, explain: ____________________

How would you describe your current dental problem? ____________________

____

Date of your last dental exam: ____________________

Date of last dental x-rays: ____________________

What was done at that time? ____________________

How do you feel about the appearance of your teeth? ____________________

____

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the three items below, please stop and return this form to the receptionist.	☐	☐	☐

Have you had any of the following diseases or problems?

	Yes	No	Don't Know
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated? ____________________

____

Date of last physical examination: ____________________

Physician: ____________________
NAME PHONE

____
ADDRESS CITY/STATE ZIP

____
NAME PHONE

____
ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem? ____________________

____

____

____

____

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify) ____________________	☐	☐	☐
Other (specify) ____________________	☐	☐	☐
Metals (specify) ____________________	☐	☐	☐

To yes responses, specify type of reaction.

____

	Yes	No	Don't Know
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? ____________________

In the past week? ____________________

	Yes	No	Don't Know
Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received treatment? (circle one) Yes / No

	Yes	No	Don't Know
Do you use drugs or other substances for recreational purposes?	☐	☐	☐

If yes, please list: ____________________

Frequency of use (daily, weekly, etc.) ____________________

Number of years of recreational drug use: ____________________

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement)?	☐	☐	☐

If yes, when was this operation done? ____________________

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

____

____

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

If yes, what antibiotic and dose? ____________________

Name of physician or dentist ____________________

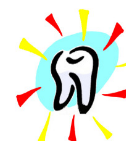
Phone: ____________________

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

Plymouth Valley Dental Group
Robert L. Adelman, DMD Associates
832 Germantown Pike, Suite 1
Plymouth Meeting PA 19462
610-277-0996



Date:

Medications:

Prescribed:

Over the Counter:

Vitamins, natural or herbal preparations and/or diet supplements:

Allergies:

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If yes, date: ___	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If yes, specify below:	☐	☐	☐

___ Angina
___ Arteriosclerosis
___ Artificial heart valves
___ Congenital heart defects
___ Congestive heart failure
___ Coronary artery disease
___ Damaged heart valves
___ Heart attack
___ Heart murmur
___ High blood pressure
___ Low blood pressure
___ Mitral valve prolapse
___ Pacemaker
___ Rheumatic heart disease/Rheumatic fever

	Yes	No	Don't Know
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, specify below: ___ Type I (Insulin dependent) ___ Type II	☐	☐	☐
Dry Mouth	☐	☐	☐
Eating disorder. If yes, specify: ___	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent Infections	☐	☐	☐
If yes, Indicate type of infection: ___			
Kidney problems	☐	☐	☐
Mental health disorders. If yes, specify: ___	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders. If yes, specify: ___	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Respiratory problems. If yes, specify below: ___ Emphysema ___ Bronchitis, etc.	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Do you have any disease, condition, or problem Not listed above that you think I should know about?	☐	☐	☐

Please explain: ___

Note: Both the doctor and the patient are encourage to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the medical and dental history form pages one and two. I acknowledge that my questions, if any, about inquiries set forth 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. I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy including nitrous oxide and local anaesthetics that may be indicated in connection with the dental care of the patient listed above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be rendered by this office.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

FOR COMPLETION BY DENTIST

I HAVE VERIFIED THE COMPLETION OF THE ABOVE MEDICAL HISTORY

Signature of Examining Dentist Date

Comments on Interview Concerning Health History:

Dental Management Concerns:

Plymouth Valley Dental Group
Robert L. Adelman, DMD Associates
832 Germantown Pike, Suite 1
Plymouth Meeting PA 19462
610-277-0996