PLYMOUTH VALLEY DENTAL GROUP

832 Germantown Pike, Suite 1
Plymouth Meeting, PA 19462

Today's date:

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	❑ Dr. ❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Sex: ❑ M ❑ F	Birth date: / /	Social Security number:

Street address:	Apt no.:	Home phone no.: ( )
		Cell phone no.: ( )
City:	State: Zip Code:	Work phone no.: ( )
		Email Address:

How did you hear about us? ❑ Dr. _____ ❑ Insurance Plan ❑ Family/Friend:_____ ❑ Other:_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Responsible party name:	Birth date: / /	Social Security No.:	Address (if different):

Employer name:	Employer Phone No.: ( )	Home Phone No.: ( )	Cell Phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No

Name of primary insurance:	Subscriber's name:	Birth date: / /	Group no.:	Subscriber ID.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance:	Subscriber's name:	Birth date: / /	Group no.:	Subscriber ID.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

DENTAL HISTORY

How would you rate the condition of your mouth?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Date of most recent dental exam: / /

Date of most recent dental x-rays: / /

I routinely see my dentist every:

❑ 3 months ❑ 4 months ❑ 6 months ❑ 12 months ❑ Not routinely

Are you fearful of dental treatment? ❑ Yes ❑ No

Check all that apply:

❑ Problems with jaw joint	❑ Chipped teeth
❑ Problems chewing	❑ Cracked fillings
❑ Teeth are crowding/spacing	❑ History of periodontal disease
❑ Clench teeth during day or sleep	❑ Sensitive to hot/cold/sweet
❑ Gums bleed when brushing/flossing	❑ Other: _____
❑ Unpleasant odor/taste in mouth	❑ _____

Do you take antibiotic premedication for your dental visits? ❑ Yes, I take: _____ ❑ No

MEDICAL HISTORY

❑ Pre-med: Amoxicillin	❑ Artificial Joints: / /	❑ Fainting / Dizziness	❑ Radiation Treatment: / /
❑ Pre-med: Clindamycin	❑ Artificial Heart Valve	❑ Headaches / Migraines	❑ Respiratory Problems
❑ Pre-med: Other: _____	❑ Asthma	❑ Heart Murmur	❑ Rheumatic Fever
❑ AIDS	❑ Blood Disease	❑ Heart Surgery / Disease	❑ Rheumatism
❑ Allergies	❑ Blood Transfusion	❑ Hemophilia	❑ Sickle Cell Disease
❑ Allergy: Aspirin	❑ Bruise Easily	❑ Hepatitis	❑ Sinus Problems
❑ Allergy: Codeine	❑ Cancer	❑ High Blood Pressure	❑ Stomach Problems
❑ Allergy: Erythromycin	❑ Chemotherapy	❑ HIV	❑ Stroke
❑ Allergy: Hay Fever	❑ Chest Pain	❑ Jaundice	❑ Swollen Ankles
❑ Allergy: Latex	❑ Chronic Cough	❑ Kidney Disease	❑ Thyroid Problems
❑ Allergy: Penicillin	❑ Cold Sore / Blisters	❑ Liver Disease	❑ Tuberculosis
❑ Allergy: Sulfa Drugs	❑ Diabetes	❑ Mental Disorders	❑ Tumors
❑ Allergy: Other: _____	❑ Emphysema	❑ Nervous Disorders	❑ Ulcers
❑ Anemia	❑ Epilepsy / Seizures	❑ Neurological Disorders	❑ Other: _____
❑ Arthritis	❑ Excessive Bleeding	❑ Pacemaker	

What is an estimate of your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Date of most recent exam: / /

WOMEN ONLY: Are you: Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Have you ever been hospitalized? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

Please describe any other medical conditions that may possibly affect your dental treatment:

List all medications, drugs, or pills or herbal remedies, including regular doses of aspirin:

The above information is true to the best of my knowledge. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to contact my health care provider or agency, who may release such information to you. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Plymouth Valley Dental Associates or the insurance company to release any information required to process my claims. I will notify the doctor of change in my health, medication, or insurance policy.

_____ _____

Patient/Guardian signature *Date*

Consent for Internet Communications

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded on my behalf.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information.

_____ _____

Patient/Guardian Name Printed Relationship to Patient

_____ _____

Patient/Guardian Signature Date

Consent for Services and Financial Policy

As a condition of treatment by this office, financial agreements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% annum) on the unpaid balance will be charges on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. There is a $45.00 fee for returned checks. Appointments cancelled without 24 hour prior notice are subject to a cancellation fee of $100.00.

I understand that any fee estimate for this dental care can only be extended for a period of one year from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment unless other arrangements have been agreed to. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver if any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I understand the above information and agree with its contents.

_____ _____

Patient/Guardian Name Printed Relationship to Patient

_____ _____

Patient/Guardian Signature Date

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand the above information and agree with its contents.

_____ _____

Patient/Guardian Name Printed Relationship to Patient

_____ _____

Patient/Guardian Signature Date