



2431 Easton Avenue, Bethlehem, Pa 18017 (610)861-0190

1050 S. Cedar Crest Blvd. Suite 104, Allentown, Pa 18103 (610)973-2090

CHILD PATIENT INFORMATION

Patient Name (CHILD) _____ M__ F__ Date of birth _____ Age _____

Child's Address _____ City _____ St _____ Zip _____

PARENT'S INFORMATION (Who is financially responsible?)

Parent's Name _____ Relationship _____

Address _____ City _____ St _____ Zip _____

Home# _____ Cell# _____ Email _____

Employer _____ Occupation _____ Work# _____

Parents Social Security# _____

Spouse Name _____ Date of Birth _____ Spouse Social Sec# _____

Spouse Employer _____ Work# _____

Emergency Contact _____ Ph# _____

HOW DID YOU FIND US?

Google__ Office Website__ Insurance Website__ Patient Name _____ Other _____

Physician _____ Phone# _____ Date Last Seen _____

Former Dentist _____ Date Last Seen _____

Pharmacy Name _____ Pharmacy Address _____

Pharmacy Phone# _____

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Dental Insurance Information Primary Insurance

Insurance Company _____ Group# _____

Name of Subscriber _____ Insured's Soc Sec OR ID# _____

Insured Date of Birth _____ Relationship to patient _____

Secondary Insurance Insurance Company _____ Group# _____

Name of Insured _____ ID or Soc. Sec. _____ #Date of Birth _____

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT. I AGREE THAT PARENTS, GUARDIANS OR PERSONAL REPRESENTATIVES ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR /CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES FOR SERVICES OR ITEMS PROVIDED TO ME, TO MY MINOR/CHILD, OR TO THE PATIENT FOR WHOM I HAVE LEGAL RESPONSIBILITY. I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE COMPANY DOES NOT RELIEVE ME FROM MY RESPONSIBILITY FOR THE PAYMENT OF ALL CHARGES.

Signature _____ Date _____

Print Name _____ **(PROCEED TO NEXT PAGE)**



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ADULT/CHILD PATIENT MEDICAL INFORMATION

Patient's Name _____

	Yes	No		Yes	No
Joint Replacement	___	___	Heart Trouble	___	___
Heart Murmur	___	___	High Blood Pressure	___	___
Mitral-Valve Prolapse	___	___	Low Blood Pressure	___	___
Pregnancy/Nursing	___	___	Nervous Disorder	___	___
Smoker	___	___	Epilepsy	___	___
Rheumatic Fever	___	___	Diabetes	___	___
Aids or HIV test (+pos)	___	___	Stroke	___	___
Hepatitis	___	___	Cancer	___	___
Venereal Disease	___	___	Hay Fever	___	___
Bronchitis	___	___	Anemia	___	___
Asthma	___	___	Radiation Therapy	___	___
Tuberculosis	___	___	Leukemia	___	___
Kidney Disease	___	___	Blood Disease	___	___
Thyroid Disease	___	___	Liver Disease	___	___

If you had a **joint replacement**, please list date of surgery and the name and phone number of the Physician

****Are there any other conditions that may be important to your care? ****

Is the patient under the care of a physician at this time or within the last 2 years?

If so, for what? _____

Has the patient been hospitalized within the past 2 years?

If so, for what? _____

Have you had an Allergic Reaction to any medication (itching, swelling, hives etc?) If so, what medication?

Are you currently taking any medications? If so, please list:

Permission is hereby granted to perform any necessary dental work and authorize my insurance company to pay the dentist or dental group all insurance benefits. I also understand that (regardless of my insurance status), I am responsible for the balance on this account for any and all services rendered to me or my dependents. I certify that this information is true and correct to my knowledge. I will notify you of any changes in my health or the information above.

Signature _____ Date _____

Print Name _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at GENTLE FAMILY DENTISTRY is to serve our customers with special care and professionalism, being sure at all times to protect privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of billing service.
- During health care operations, we may need a second opinion.

We here at GENTLE FAMILY DENTISTRY are committed to observe all federal, state, and local laws and regulations regarding Privacy practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding your protection health information, please contact our office at (610)861-0190.

I have read and understand the above Notice of Privacy Practices.

Signed _____ Date _____

(Patient or legal Guardian)

Print Name _____

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Office Policies and Procedures

- The Dentist have reserved valuable time for your appointment. Please honor the scheduled appointments and arrive on time. If you are unable to keep your appointment a 48hours notice is required, otherwise a **\$50.00 fee** will be charged to your account.
- **Deductibles** (if applicable) and **co-payments** for services rendered are **due at the start of the visit**. Due to increasing incidence of NON-PAYMENT by patients for services rendered, all outstanding and overdue balances will be collected prior to being seen for any Non-emergency office visits. **ALL CO-INSURANCE AND VISITS NOT COVERED BY YOUR INSURANCE WILL BE COLLECTED AT THE TIME OF SERVICE.** We give estimated amount due the fact your insurance plan may use a different fee schedule then what is supplied to us from your insurance plan. **IF YOU ARE UNABLE TO MEET THESE REQUIREMENTS PLEASE INFORM US PRIOR TO YOUR VISIT SO THAT WE CAN RESCHEDULE YOUR APPOINTMENT.**
This policy has been approved and agreed by all physicians in this practice.
- (If applicable) I am the parent, guardian or representative of _____
(Please print name of minor/child) and there are no court orders now in effect that prohibits me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child name above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the dentist, whether or not I am present when the treatment is rendered.
- **Simple Agreement:** Patient authorizes the Doctor to deposit checks received on patient's accounts and authorizes credit card payments by phone and mail.

I, _____ understand that if I am delinquent on my obligation to pay Gentle Family Dentistry, then I will be responsible for any fees, interest charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence.

Signature _____ Date _____
Print Name _____

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IMPORTANT, PLEASE READ: REGARDING YOUR INSURANCE BENEFITS

Dear Patient,

We do our best to verify your insurance. Occasionally, we receive incorrect information from your insurance company. We must inform you that the information we tell you concerning your insurance benefits is not always what the insurance company ends up paying. You may have a deductible, co-insurance or co-pay that we were not informed about.

When the Explanation of Benefits (EOB) is received from the insurance company, our billing department posts the amount paid. If at that time we discover you have additional out of pocket expenses such as deductible, co-insurance or co-payments, you will be responsible for payment.

We urge you to contact your insurance company to find out what your benefits are.

We will not be held responsible for co-insurances, deductibles, out of out of pocket expenses, or co-pays that we are not informed about or do not know about.

Thank you

Print Patient Name: _____

Signature: _____

Date: _____