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

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

ADULT PATIENT INFORMATION

Patient Name________________________________ M__ F__ Date of Birth__________ Age________

Home#____________________Cell#_____________________Email______________________________

Home address____________________________________City__________________St___Zip______

Employer_________________________________Occupation______________Work#______________

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_____________________ Address____

Pharmacy#______________________________

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__________

PERMISSION IS HEREBY GRANTED TO THE DOCTOR TO PERFORM ANY NECESSARY DENTAL WORK. I ACKNOWLEGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT. I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE DOES NOT RELIEVE ME FROM MY RESPONSIBILITY FOR THE PAYMENT OF ALL CHARGES. I CERTIFY ALL THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THE INFORMATION PROVIDED ABOVE.

Signature____________________________ Date________________________

SIGN AND 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 deductable, 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 deductable, 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: ____