PENN VALLEY DENTAL

GENERAL DENTISTRY

PATIENT REGISTRATION AND HEALTH HISTORY

Name _____ Single Married Divorced Separated Widowed

Residence Address _____ City _____ State _____ Zip _____

Name of Spouse _____ Home Phone _____ Your Social Security Number _____

Employed By _____ City _____ State _____ Business Phone _____

Spouse Employed By _____ City _____ State _____ Phone _____

Person Responsible For Account If Other Than Patient _____ Address _____

Referred By _____

Name of Your Dental Insurance Company _____ Union Local _____ Group No. _____ Policy No. _____

Spouse's Dental Insurance Company _____ Social Security # _____ Group No. _____ Policy No. _____ Birthdate _____

DENTAL HISTORY

Reason for the visit? _____

How long has it been since your last visit to Dentist? _____

What was done at your last dental visit? _____

How often did you visit the Dentist before than? _____

Have you lost any teeth? _____ If yes, Why? _____

Have missing teeth been replaced? _____

Have you had your teeth straightened? _____

How often do you brush your teeth? _____ Do you use dental floss? _____

Have you been show how to brush and floss by a Dentist or Hygienist? _____

Do you have any fear of having dentistry done? _____

If yes, why? _____

Have you had any problems with your teeth or dental treatment that you feel I should know about? _____

Are there any questions or concerns about your teeth you want to ask us about? _____

MEDICAL HISTORY

It is important that I know about your medical history. Many things have a direct bearing on your dental health. I will review this questionnaire with you. If you have any questions or are unsure of an answer please call it to my attention. Your answers are held in the strictest confidence and will not be released to anyone without your written permission.

PHYSICIAN'S NAME_____

Birthdate_____

Do you have or you had any of the following. Please answer Yes or No.

_____ ANY HEART PROBLEMS
_____ HIGH BLOOD PRESSURE
_____ LOW BLOOD PRESSURE
_____ CIRCULATORY PROBLEMS
_____ NERVOUS PROBLEMS
_____ RADIATION TREATMENTS
_____ EXCESSIVE BLEEDING
_____ AIDS
_____ ALLERGIES TO ANESTHETICS (NOVOCAINE)
_____ ALLERGIES TO MEDICINES OR DRUG
_____ ALLERGIES TO _____
_____ ANEMIA
_____ ARTHRITIS
_____ ASTHMA
_____ DIABETES
_____ ARE YOU PREGNANT
_____ ARTIFICIAL JOINT

_____ HEPATITIS
_____ HERPES
_____ MALIGNANCIES (CANCER)
_____ MEASLES
_____ MUMPS
_____ PSYCHIATRIC CARE
_____ RHEUMATIC FEVER
_____ SCARLET FEVER
_____ SINUS PROBLEMS
_____ STROKE
_____ TYPHOID FEVER
_____ TONSILLITIS
_____ TUBERCULOSIS
_____ ULCER
_____ VENEREAL DISEASE
_____ OTHER

Are you currently under a doctor's care?_____

If yes, for what reason?_____

_____

_____

Are you currently taking any drug or medications?_____

If yes, Please list:_____

_____

_____

Please describe any current medical treatment, impending operations or any other medical or dental information that may affect your dental treatment.

_____

_____

_____

_____

Date:_____ Your Signature_____

Reviewed with Patient_____ Date:_____

Penn Valley Dental

FINANCIAL AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family.

Our professional services are rendered to patients, thus patients are responsible for charges for treatments rendered. We are unable to provide services on the assumption that the charges will be paid by the insurance company. The insurance company is responsible to the insured patient. With or without insurance coverage, patients are responsible for full payment of the total bill, unless prior arrangements have been made. _____ **(initials)**

- The following methods of payment are accepted: Cash, Checks, Visa, Master Card, American Express, Discover Card, Care Credit.
- **Insurance assignment and management:**
  - Patients must provide Penn Valley Dental with accurate/current insurance billing information at the time of their appointment, or they are responsible for payment in full.
  - Insurance benefits are a contract between the patient and his/her employer.
  - **The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor.**
  - Patients are responsible for paying **their deductible and their co-pay** at the time of service. Patients are also responsible for paying all charges not covered by your insurance plans including all fees considered above their insurance policy's usual and customary fee schedule at the time of service. _____ **(initials)**
  - Patients are responsible for submitting required paper work such as proof of student status to their insurance company. Any balance caused by insurance denial due to missing information is the patient's responsibility.
  - The office will submit a claim up to two (2) times per appointment. Further insurance appeal becomes the patient's responsibility. _____ **(initials)**
  - As an office courtesy, we will accept assignment for the primary insurance coverage. Secondary insurance must be paid to the patient. _____**(initials)**

- **Patients are responsible for balance in full after 60 days even if their insurance company has not paid. Further insurance appeal becomes the patient's responsibility.** _____ **(initials)**
- The practice cannot carry balance longer than 90 days. Patients will be informed that their accounts are delinquent before any collection efforts are made.
- Treatments such as root canal therapy, crowns, dentures, and other cosmetic procedures such as whitening require a deposit before treatment is started. The **deposit** amount must be no less than **1/2 of the total cost.** The remaining balance must be **paid in full before final insert and treatment.**
- A service charge of $30.00 will be assessed to your account for any checks returned by your bank.
- **Last minute appointment changes**- Same day and day before cancellations or missed appointments will have a $30.00 charge for every 30 minutes of appointment time scheduled plus one or more hours reserved appointment times will forfeit deposit. The notice must be received Monday thru Thursday. _____ **(initials)**

I have read and accepted the above Financial Agreement. I understand it, and agree to all payments terms regarding my account.

Patient or Parent/Guardian Signature **Date**

408 N Keystone Ave, Sayre, PA 18840 Ph: (570) 888-5811 Fax: (570) 888-5607

H.I.P.P.A. Consent Form

Yes / No — Can we contact you at home? Please list the phone number where we may contact you. (_____)_____-_____

Yes / No — Can we leave a message with a family member? Is there anyone in your home we are not allowed to leave a message with? _____

Yes/ No — May we send a letter or postcard when insurance approvals and or lab work is in?

Please list the name and contact information of the person we may contact in case of emergency below:

Name of person: _____

Relationship:_____

Telephone #:(_____)_____-_____

This form is to certify that you have read the notice of our offices privacy practices located by the reception desk. By signing this form you are authorizing us the consent to use and disclose the information in the manner that is described in the fore- mentioned notice.

Print Patient Name:_____

Signature of Parent/Guardian (if patient is under 18)_____

Date Signed:____/____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

** You may refuse to sign this acknowledgement**

I have received a copy of this office's "Notice of Privacy Practices" and understand that I have the right to opt out of the following.

Optional Information Disclosures

Telephone calls containing general information e.g. "results are negative or within normal limits, scheduling etc" may be left on answering machine or with adult answering the phone. **Yes/NO**

I authorize private dental information to be disclosed to my insurance company as requested. **Yes/NO**

I authorize dental records and dental images/x-rays to be disclosed as considered necessary by my dental provider and this office. **Yes/NO**

Signature:_____ **Date:**____/____/____

You may revoke permission to disclose any of your dental information in the future if necessary by putting it in writing and submitting it to this office.