

How did you find us? Person?: _____ Internet Yellow Pages Other _____

New Patient Information

Patient Name: _____ Date of Last Dental Visit: _____
Last, First MI (Preferred or Nick Name)

Gender: Male Female, Family/Marital Status: Married Divorced Single Other: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Phone #'s (Home): _____ (Cell): _____ (Work): _____ Ext: _____ Hours: _____

Employer /School Name: _____ Occupation: _____

Insurance Co: _____ Email Address: _____
Name

Home Address: _____
Street Apartment #

_____ City State Zip Code

Patient's Medical & Health Information

Reason for Today's Visit: _____

Do you now or have you ever had any of the following? Please check all that apply: I need the following Pre-Med's: _____

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> BP Med's? _____ | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> HIV + _____ | <input type="checkbox"/> Stomach Problems: _____ |
| <input type="checkbox"/> Erythro Allergy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hay Fever Allergy | <input type="checkbox"/> Blood Disease: _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | OTHER: |
| <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> ? _____ |
| <input type="checkbox"/> Tylenol Allergy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Past Pregnancy | OTHER: |
| <input type="checkbox"/> Other Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnant Now | <input type="checkbox"/> ? _____ |
| <input type="checkbox"/> Other Allergies _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Your Due Date: _____ | OTHER: |
| <input type="checkbox"/> Other Allergies _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> ? _____ |
| | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | |
| | <input type="checkbox"/> Hepatitis: _____ | <input type="checkbox"/> Rheumatic Fever | |

• Have you had complications after dental treatment? No Yes, Explain: _____

• In the past two years have you been hospitalized or visited the E.R.? No Yes, Explain: _____

• Are you under the care of a physician? No Yes, Explain: _____

• Physician's Name: _____ Phone: _____

• Any other health problems the Dentist should know about? No Yes, Explain: _____

All information provided is true and correct. And I will inform Glenside Dental of any changes in my health or personal information.

 _____ Today's Date: _____

Signature of patient, parent or guardian

Financially Responsible Party Information Insured Parent Spouse Other _____

Name: _____ Are You Our Patient Too? _____
Last, First MI (Preferred or Nick Name)

Gender: Male Female, Family/Marital Status: Married Divorced Single Other: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Phone #'s (Home): _____ (Cell): _____ (Work): _____ Ext: _____ Hours: _____

Employer Name: _____ Occupation: _____

Insurance Co: _____ Group #: _____ ID #: _____ Phone #: _____
Name Provider or Claims Toll Free #

Same as Patient

Home Address: _____
Street Apartment #

_____ City State Zip Code

GLENSIDE DENTAL'S FINANCIAL POLICY

1. **PATIENT BALANCES:** Full payment is due on the day services are rendered. For your convenience, we offer several payment options including: cash, check, debit/credit cards (MasterCard, Discover, Visa and Amex). For those patients who qualify, third-party financing is also available through Care Credit. We also offer an in-house payment plan for services that are \$300.00 or more. This option requires you to make automatic payments each month with your credit or debit card. (See the office manager for more details)
2. **INSURANCE PATIENTS:** We participate with most PPO insurance plans, however we unfortunately do not accept ANY DMO'S at this time. We will gladly submit your insurance claim for you. You are responsible for all deductibles , co-insurance and non-covered services at the time services are rendered. If we do not participate with your insurance company we will still file a claim for you, but you are responsible for all charges incurred. Please remember, your insurance policy is a contract between you, your employer, and the insurance company. We are not party to that contract. Our financial relationship is with you. All charges are your responsibility, whether your insurance pays or not. Some services may not be covered as some insurance companies arbitrarily select certain services that will not be covered.
3. **ESTIMATED FEES:** When a procedure is scheduled/performed, an **ESTIMATE** of insurance coverage and fees is obtained from your insurer. While we make the best effort to be as accurate as possible, your final balance may differ from what was quoted to you. You are responsible for all estimated portions and any balances incurred after insurance has made their payment.
4. **LAB CASES:** For patients needing crowns, dentures, bridges or any other treatment that is made by a third-party lab, 50% of the fee is due at the time impressions are taken. The balance is due at the time of delivery/cementation.
5. **MISSED APPOINTMENTS:** Please make every effort to contact our office as soon as possible if you are unable to make it to your scheduled appointment. For existing patients, If a treatment appointment is cancelled, rescheduled or missed **3** times, you will be asked to pay your portion before another appointment will be scheduled for you.
6. **RETURNED CHECKS:** If your check is returned or dishonored for any reason, the bank will electronically debit your account for the amount of your check plus a \$50.00 processing fee.
7. **UNPAID BALANCES:** Charges reflected on billing statements are assumed to be fair and reasonable unless disputed within 30 days of the billing date. Glenside Dental does billing at the first of the month each month. A total of 3 statements will be sent to you, the third one being a warning that if the balance is not taken care of, or a payment plan created your account will be forwarded to a collection agency where additional fees will be accrued.

I have received and I understand these policies and I agree to the terms listed above.

X

PATIENT

DATE

Glenside Dental's Privacy Policy

Dear Patient,

We here at Glenside Dental believe in your privacy. We follow the H.I.P.P.A law and maintain the privacy of your health and personal information. For more detailed information about our privacy practices, you may request a copy of the "Notice of Privacy Practices" at any time. You may also contact the U.S. Dept, of Health and Human Services for more info on H.I.P.P.A.

I, _____, have reviewed and agree to Glenside Dental's financial and privacy policies.

X

PATIENT

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