FAMILY & COSMETIC ALWAYS DENTAL CARE

Today's Date:	Referred By:	Email Address:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle: [Initial]

Birth Date:	Age:	Sex: ○ M ○ F Address: _____ City: _____ State: _____ Zip Code: _____

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

- Physician's Name:
- Physician's Number:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No		

Please indicate **PRIMARY** Insurance name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:

Patient's relationship to subscriber:

Name of Secondary insurance (if applicable):	Subscriber's name:	Group no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

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Patient Name:_____

MEDICAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy which is available upon request.

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this *(Please check box)*. ❑

	No	Yes
Do you require an antibiotic before dental treatment?		
Have you had any abnormal reactions to local or general anesthesia?		
Do you smoke?		
Are you pregnant? *(Females only)*		
Are you being treated by a doctor at present?		
Are you taking any prescription or other medications at present?		
Have you been hospitalized in the last 12 months?		
Have you or anyone in your household returned from overseas travel in the last 14 days?		

Please list current medications:

Please list any drugs or medicines you are allergic to:

Please list any other known allergies (including latex, foods and preservatives):

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please check either yes or no for each condition

	No	Yes		No	Yes		No	Yes
Steroid therapy			Kidney disease			Prosthetic (Ex: Hip, Knee)		
Rheumatic fever			Excessive Bleeding			Cardiac pacemaker		
Epilepsy			Stroke			Stomach or digestive condition		
Asthma			Cancer			Hepatitis, AIDS, or liver diseases		
Diabetes			Thyroid disease			Contact with blood-borne viruses		
Heart Disease			Snoring/ Sleep Apnea			Bronchitis, emphysema or other lung diseases		
Bone disease			Anxiety/ Depression			Anemia, Leukemia or other blood diseases		
Radiation therapy			High or Low blood pressure			Any other conditions		

Any other condition(s) not mentioned *(please list):*

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

Signature of Patient, Parent or Guardian: Date:

Financial Information and Billing

We at ***Always Dental Care*** are proud to deliver the finest and most comprehensive dental care. In order to assist you with your dental treatment, we are providing the following payment options:

A) Insurance:

We will gladly process your insurance claim. In order to do so we request authorization to release any information including diagnosis, any/all records for you or your child, to the 3rd party payers and/or other health care practitioners. We also request authorization for insurance carriers to pay directly to our dental practice. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by any of the options listed below. Our estimates are subject to final approval by your insurance company; therefore, the amount due to our office is subject to change. We strongly suggest you verify your individual insurance coverage as well to insure the utmost accuracy.

It is ultimately your responsibility to know your individual insurance coverage.

B) Initial Payment:

Our office requires a deposit of one half (1/2) at the start of treatment and payment in full once treatment is completed. There will be a 1.5% finance charge and 18% fee for outstanding accounts with balances over 90days and additional fees if a collection agency is involved.

C) Payment Options:

In the event your insurance does not cover your services at 100%, or does not cover them at all, we accept the following payment methods. Check one of the following options below:

_____ 1. **CASH-**Includes money orders and personal checks. There will be a $25.00 charge for all returned checks.

_____ 2. **CHARGE CARD-**We accept Visa, Mastercard, Discover and American Express as payment for treatment to the extent your credit limit permits.

_____ **3. CARE CREDIT-** Care Credit is a third party credit company used for medical, dental, vision copays. There is a minimum copay of $500 and a finance charge will be applied for using this payment method.

D) Refund Policy:

If a refund is determined to be owed due to the dentist changing the treatment plan, or due to overestimated insurance copays, Always Dental Care will be happy to refund the patient, insurance, or third party lender. This will occur within 30 days of approval providing that all open insurance claims have been paid on the account.

_____ _____

Signature of Patient or Parent (If minor) Date

APPOINTMENT CANCELLATIONS OR CHANGES POLICY

Always Dental Care requires a 48 hour notice for any and ALL cancellation or appointment changes. If a 48 hour notice is not given, there will be a $100.00 charge. This charge is ***NOT*** a covered benefit by your insurance, and will be **your** responsibilty. After (3) missed or late appointments without proper notification, you will be asked to seek treatment elsewhere. Should you wish to obtain a copy of your records we will be happy to provide them to you. We will allow you to be no more than 5 minutes late.

I, _____, have reviewed and understand *Always Dental Care's* policy for any appointment change without proper notification.

Print Name _____

Patient, Parent or Guardian's Signature _____

Date: _____

1570 Egypt Road, Suite 210, Phoenixville, PA 19460 • P 484-392-7687 • F 484-392-7688 • www.alwaysdentalcare.com

Patient Communication (HIPPA)

By Law, without your authorization, Always Dental Care cannot communicate with:

1. **Spouse**
2. **Your adult children or caregivers**
3. **Your parents (if you are age 18 or over)**

Always Dental Care may need to communicate with your family or caregivers in the following circumstances:

1. **Making appointments**
2. **Confirming appointments**
3. **Discussing treatment needed or performed**
4. **Account or Finanical Information**

Please indicate below the names of people who we may communicate with regarding your appointment, medical/dental needs, or account information:

- **Spouse** _____
- **Adult Children** _____
- **Parents** _____
- **Caregiver** _____
- **Other** _____

( ) I do not wish to disclose any information with anyone.

Emergency Contact: _____

Phone: _____

Patient Name (Printed): _____

Patient /Parent/Legal Guardian Signature: _____

Date: _____

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