

Welcome to Our Practice!

Patient Information

Patient's Last Name	_____	First Name	_____					
Middle	_____	Title	_____	Preferred Name	_____	Marital Status	_____	
Social Security	_____ - _____ - _____	Birth Date	____/____/____					
Street Address	_____							
City	_____	State	_____	Zip Code	_____			
Home Phone	_____ - _____ - _____	Cell Phone	_____ - _____ - _____					
Work Phone	_____ - _____ - _____	E-Mail	_____					
Occupation	_____						Employer	_____
Employment Address	_____							
Emergency Contact	_____						Phone	_____ - _____ - _____
Relationship to Patient	_____							
Whom may we thank for referring you to our office?	_____							
For Full-Time College Students: School	_____							
Phone at School	_____ - _____ - _____							
Email at School	_____							

Responsible Party Information (if different from above)

Responsible Party Last Name_____	First Name_____
Middle_____	Title_____ Preferred Name_____ Marital Status_____
Social Security_____ - _____ - _____	Birth Date_____/_____/_____
Street Address_____	
City_____	State_____ Zip Code_____
Home Phone_____ - _____ - _____	Cell Phone_____ - _____ - _____
Work Phone_____ - _____ - _____	E-Mail_____
Occupation_____ Employer_____	
Employment Address_____	

Insurance Information

Subscriber- Last Name_____	First Name_____
Middle_____	Is insured a patient? Yes No Insured's Relationship to Patient_____
Insured's Social Security_____ - _____ - _____	Insured Birth Date_____
Insurance Company_____	
Insurance ID #:_____	Insurance Group #_____
Insurance Company Phone_____ - _____ - _____	Insured's Employer_____
Employment Address_____	Work Phone_____ - _____ - _____
<i>If you have dual coverage, please complete the following secondary insurance information</i>	
Subscriber-Last Name_____	First Name_____
Middle_____	Is insured a patient? Yes No Insured's Relationship to Patient_____
Insured's Social Security_____ - _____ - _____	Insured Birth Date_____
Insurance Company_____	
Insurance Company Phone_____ - _____ - _____	Insured's Employer_____
Employment Address_____	Work Phone_____ - _____ - _____

Medical Information

Are you currently under medical treatment? Yes No

Have you been a patient in the hospital during the past two years? Yes No

Date of most recent medical exam: _____

Physician's Name _____ Physician's Phone _____

Please list any medications or drugs you are currently taking, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins, etc. _____

Please list any medications or anesthetics to which you are allergic _____

Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart Failure	Yes	No	Sinus Trouble	Yes	No	Whiplash Injury	Yes	No
Heart Disease or Attack	Yes	No	Hay Fever	Yes	No	Severe Blow to Head	Yes	No
Angina Pectoris	Yes	No	Respiratory Problems	Yes	No	Severe Blow to Jaw	Yes	No
Congenital Heart Failure	Yes	No	Allergies	Yes	No	Chronic Back Pain	Yes	No
Heart Murmur	Yes	No	Latex Allergy	Yes	No	Chronic Shoulder Pain	Yes	No
High Blood Pressure	Yes	No	Codeine Allergy	Yes	No	Chronic Neck Pain	Yes	No
Arteriosclerosis	Yes	No	Penicillin Allergy	Yes	No	Stiff Neck Muscles	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatitis A (infectious)	Yes	No	Tension Headaches	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis B (serum)	Yes	No	Migraine Headaches	Yes	No
Heart Pacemaker	Yes	No	Hepatitis C	Yes	No	Headaches in Back of Head	Yes	No
Heart Surgery	Yes	No	Venereal Disease	Yes	No	Headaches in Temple Area	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No	Chronic Facial Pain	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No	Pain in Jaw Joint	Yes	No
Anemia	Yes	No	Hemophilia	Yes	No	Clicking, Popping Jaw	Yes	No
Arthritis	Yes	No	Sickle Cell Disease	Yes	No	Locking Jaw	Yes	No
Rheumatism	Yes	No	HIV	Yes	No	Tired Jaw After Sleep	Yes	No
Cortisone Medication	Yes	No	Easy Bruising	Yes	No	Tired Jaw After Meal	Yes	No
Artificial Joints (hip, etc)	Yes	No	Yellow Jaundice	Yes	No	Foods You Avoid	Yes	No
Liver Disease	Yes	No	Epilepsy or Seizures	Yes	No	Aching Jaw Opening Wide	Yes	No
Kidney Trouble	Yes	No	Nervousness	Yes	No	Difficulty Opening Wide	Yes	No
Diabetes	Yes	No	Anorexia/Bulimia	Yes	No	Trouble Sleeping	Yes	No
Ulcers	Yes	No	Wisdom Tooth Extraction	Yes	No	Cracking in Jaw Joint	Yes	No
Thyroid Problems	Yes	No	Bleeding Gums	Yes	No	Teeth Clenching	Yes	No
Glaucoma	Yes	No	Family History of Jaw Problems	Yes	No	Teeth Grinding at Night	Yes	No
Cancer	Yes	No	Ear Pain	Yes	No	Sore Teeth After Sleep	Yes	No
Radiation Therapy	Yes	No	Itchiness in Ear	Yes	No	Blurred Eyesight	Yes	No
Chemotherapy	Yes	No	Stuffiness in Ear	Yes	No	Snoring	Yes	No
Emphysema	Yes	No	Ringling/Buzzing in Ear	Yes	No	Chronic Stuffed Nose	Yes	No
Chronic Cough	Yes	No	Loss of Hearing	Yes	No	Recurring Nausea	Yes	No
Tuberculosis	Yes	No	Pain In/Around/ Behind Ear	Yes	No	Hives	Yes	No
Tumors	Yes	No	Fainting or Dizzy Spells	Yes	No			
Asthma	Yes	No	Involvement in Accident	Yes	No			

Financial Responsibility

Consent:

1. I understand that the above information is necessary for the doctors to provide me with comprehensive dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge
2. I authorize the doctors of Pearly Whites, LLC to take radiographs and photographs, make study models, or employ other diagnostic aids deemed appropriate by them for the purpose of making a thorough diagnosis of my dental needs.
3. I authorize the doctors of Pearly Whites, LLC to perform all recommended treatment with which I have agreed and to use the appropriate medication and therapy indicated for such a treatment. I understand that using anesthetic agents embodies a certain risk.
4. I authorize the release of examination findings, diagnosis, treatment program, etc., to my referring or treating dental specialists and/or physicians.
5. I understand that all responsibility for payment for dental services provided in this office for myself and/or for my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
6. If I have dental insurance, I realize that my insurance coverage represents a contract between my insurance company and me and that said coverage depends upon the plan that I have chosen or that the insured's place of employment has purchased on my behalf. I am aware that some procedures I may require may not be a benefit of my particular plan. I also understand that Pearly Whites, LLC submits my claims to my insurance carrier purely as a courtesy to me. Should insurance payment be denied or should reimbursement be less than the estimate amount, I am responsible for the treatment fee in full.
7. If I have dental insurance, I realize that I am responsible for maintaining contact with my insurance carrier though the phone number on my insurance card in order to monitor reimbursement paid throughout the contact year relative to the maximum coverage allowed. Should the maximum benefit coverage be exceeded in a given contract year, I am responsible for the balance that remains.
8. I understand that it is my responsibility to advise of any information contained in this form.
9. If I am 18 years of age or older and if my parents/guardians are my guarantors, I give permission for Pearly Whites, LLC to submit dental claims on my behalf to the insurance company to white my parents/guardians subscribe. I give permission for Pearly Whites, LLC to place a phone call to my parents'/guardians' home regarding those claims, account balances, and/or account credits and/or to mail statements or other information to my parents'/guardians/ home address regarding those claims, account balances, and/or account credits.

Patient Signature _____ Date _____

OR

Signature of Parent or Responsible Party _____

Relationship to Patient _____ Date _____

Cancellation Policy

We need to ensure that our office stays on schedule so each that patient is seen on time. If you are unable to keep an appointment, we require that you provide us with two business days notice for rescheduling. We understand that situations may arise and this notice will allow us to offer an appointment to another patient in need of treatment.

If an appointment is cancelled or missed without notifying our office within the requested time, we reserve the right to charge a fee of \$50.00 for revenues lost. All fees must be paid prior to rescheduling another appointment.

Thank you for your understanding, Pearly Whites only wishes to insure each patient with the amount of time and care required.

Patient Signature _____ Date _____

SECTION A: Consent of Patient

Name_____

Address_____

Home Phone_____ - _____ - _____ Cell Phone_____ - _____ - _____

E-Mail_____

Social Security Number_____ - _____ - _____

SECTION B: To The Patient- *Please read the following statements carefully*

Purpose of Consent: By the signing of this form, you hereby consent our use and disclosure of your information regarding your health to carry out treatment, have access to payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. Pearly Whites, LLC provides a description of our treatment, payment activities and healthcare options, of the uses of disclosure we make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and understand prior to you signing this consent. Pearly Whites, LLC reserves the right to change its Privacy Practices as described in our Notice of Privacy Practices. If any changes were to be made, we will reissue a revised Notice of Privacy Practices which will contain these changes. These changes may apply to any of your protected health information we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice of Privacy Practices at any time by contacting our office at (215)295-4851,or by mailing us at 799 West Trenton Avenue, Morrisville, PA 19067.

RIGHT TO REVOKE: You will have the right to revoke This Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action Pearly Whites, LLC took prior to receiving your revocation and that we reserve the right to decline further treatment to you if and after you revoke this consent.

SIGNATURE:

I, _____, have had the full opportunity to read and consider the contents of this consent form and your use and disclosure of my protected health information and to carry out treatment, payment activities and health care operations.

Signature_____ Date_____

If this consent is hereby a personal representative/guardian on behalf of the patient, please complete the following:

Representative/Guardian Name: _____ Relationship_____

Signature of Personal Representative/Guardian_____