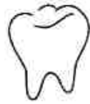


DENTAL SURGEONS & ASSOCIATES
419 NORTH CHESTNUT ST.
SCOTTDALE, PA 15688

PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT NAME: ______________________ DOB: ______________ SEX: _____ MARITAL STATUS: ______________

HOME ADDRESS: ________________________ CITY: ____________________ STATE: _______ ZIP: ________

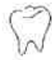
BILLING ADDRESS: ______________________ CITY: ____________________ STATE: _______ ZIP: ________

HOME PHONE: _______________________________ MOBILE PHONE: __________________ OK TO TEXT Y or N

EMPLOYER/OCCUPATION: __________________________ WORK PHONE: ______________________________

SOCIAL SECURITY # ______________________________ EMAIL: _____________________________________

EMERGENCY CONTACT NAME: ____________________________ EMERGENCY NUMBER: ____________________



INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE: ______________________ MEMBER # ______________________________

SUBSCRIBERS NAME: __________________________ DATE OF BIRTH ______________ SS# ______________

SECONDARY DENTAL INSURANCE: __________________ MEMBER # ______________________________

SUBSCRIBERS NAME: __________________________ DATE OF BIRTH: ______________ SS# ______________

YOUR MEDICAL DOCTOR: ________________________ DATE OF LAST VISIT TO MEDICAL DOCTOR: ______________

NAME OF PREVIOUS DENTIST: ____________________ DATE OF LAST DENTAL VISIT: ____________________

REFERRED TO US BY: ____

DENTAL HEALTH HISTORY

***Are you required by a physician to PREMEDICACTE previous to dental work?**

Y or N

***Reason for your visit today?** ______________________________

____

Do you feel twinges of pain when your teeth come in contact with...

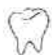
	Hot foods or liquids	Y or N
	Cold foods or liquids	Y or N
	Sours	Y or N
	Sweets	Y or N

Do you wear dentures?	Y or N
Do you wear a partial?	Y or N
Have difficulty chewing?	Y or N
Do your gums bleed easily?	Y or N
Do gums bleed when you floss?	Y or N
Do your gums feel tender or swollen?	Y or N
Do you clench or grind your teeth?	Y or N
Do your jaws ever feel tired?	Y or N
Is your mouth dry?	Y or N
Do you have earaches or pain around ears?	Y or N
Have you ever had trauma to the jaw?	Y or N
Do you gag easily?	Y or N
Does food catch between your teeth?	Y or N
Are your teeth sensitive?	Y or N
Do you take fluoride supplements?	Y or N
Do you prefer to save your teeth?	Y or N
Are you a habitual gum chewer?	Y or N
Have you had periodontal (gum) treatment?	Y or N
Have you ever had orthodontic treatment?	Y or N

How often do you brush? ______________

How often do you floss? ________________

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses on this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use information to discriminate.



MEDICAL HEALTH HISTORY QUESTIONS:

Do you have, or have you had, any of the following?

Height________________Weight________________

Under the care of a physician? Y or N
Are you in good health? Y or N
Fainting Spells Y or N
Seizures Y or N
Epilepsy Y or N
Stroke(s) Y or N
Frequent or severe headaches Y or N
Thyroid Problems Y or N
Persistent Cough Y or N
Swollen Glands Y or N
Cancer/Tumor Y or N
Chemotherapy/radiation Y or N
Jaundice/Liver trouble Y or N
Hepatitis Y or N
If yes, please specify Type____________________.
HIV Positive/AIDS Y or N
STD Y or N
Herpes Y or N
Glaucoma Y or N
Do you wear contacts Y or N
History of head injury Y or N
Neurological Disease Y or N
Special Needs Y or N
Mental Disorder (specify) ____________________ Y or N
Do you drink alcohol? Y or N
If so, how much per week?
Do you use tobacco? Y or N
If yes, how much per week?
Do you use controlled substances Y or N
MRSA Y or N
Diabetes Y or N

Bone or Joint Problems Y or N
Arthritis Y or N
Back or neck pain Y or N
Joint Replacement Y or N
Please specify________________(date)____________.

Blood Problems
Anemia Y or N
Hemophilia Y or N
Abnormal bleeding Y or N
Blood transfusion (date) ______________ Y or N

Women
Are you pregnant Y or N
How many weeks____________________.
Are you nursing Y or N
Taking contraceptives or other hormones Y or N
If so, please specify:

Respiratory Problems
Active Tuberculosis Y or N
Sinus Problems Y or N
COPD Y or N
Asthma Y or N

Heart Problems
High Blood Pressure Y or N
Low Blood Pressure Y or N
Heart Murmur Y or N
Heart Attack Y or N
If so, date?____________________
Rheumatic fever Y or N
Pacemaker Y or N
Congenital heart disease
Unrepaired, cyanotic CHD Y or N
Repaired(completely) in last 6 mos. Y or N
Repaired CHD with residual effects Y or N
Damaged valves in transplanted heart Y or N
Artificial (prosthetic) heart valve Y or N
Previous infective endocarditis Y or N
Mitral Valve Prolapse Y or N
Congestive Heart Failure Y or N

Are you allergic or had reactions to any of the following?

Local anesthetics Y or N
Penicillin Y or N
Sulfa drugs Y or N
Aspirin, Acetaminophen, or ibuprofen Y or N
Codeine, Demerol, or other narcotics Y or N
Reaction to metals Y or N
Latex Y or N
"list all others"______________________________

PLEASE LIST ALL CURRENT DRUGS/MEDICATIONS

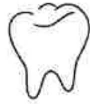
____
____
____
____
____

***Are you taking or to begin taking FOSAMAX or ACTONEL for osteoporosis or Paget's Disease?** Y or N

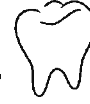
***Since 2001, were you treated or are you scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia, or skeletal complications resulting from Paget's Disease, multiple myeloma, or metastatic cancer?** Y or N

Date that treatment began?____________________

Any disease or condition not listed that we should know about: ______________________



DENTAL SURGEONS & ASSOCIATES



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Information Release Form (HIPPA)

Name: ______________________________________ **Date of Birth:** ____/____/____
(FIRST) (MI) (LAST)

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to (PLEASE LIST ALL NAMES);

Spouse______________________________________.

Child(ren)______________________________________.

Other______________________________________.

( ) Information is NOT to be released to anyone

This release of information will remain in effect until terminated by me in writing.

X Patient Signature______________________________________**Date**______________

Messages

Please call ( ) my home ( ) my work or my ( ) my cell number____________________

( ) You may leave a detailed message

( ) Please leave a message asking me to return the call

The best time to reach me is (day)________________between (time)____________

X Patient Signature ______________________________________ **Date**______________

Acknowledgement Of Our Notice Of Privacy Practices

I hearby acknowledge that I have received or have been given the opportunity to receive a copy of Dental Surgeon's & Associates Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

X Patient Signature______________________________________**Date**__________

Honesty policy:

I certify that I have read and understand all information in this agreement. The information that I provided on these forms is accurate to the best of my knowledge. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

X PATIENT SIGNATURE______________________________________**DATE**______________

Financial Agreement

Thank you for choosing Dental Surgeons & Associates! Our goal is to help patients understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all of our patients. Please review the following policies and procedures:

Payment Policy: Payment is due at the time services are rendered. If you have dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

- We accept cash, personal checks with proper ID, money orders and most major credit cards.
- You will be responsible for a check returned by the bank of $35.00.
- Financing is available through Care Credit with prior approval.
- You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/ or attorney fees).
- You understand that any treatment involving a Lab's fabrication, will incur a fee within 60 days of the case being received, even if you decide not to continue with the agreed treatment.
- **MINOR PATIENTS:** In the case of divorced or separated parents, it is **YOUR** responsibility to have financial arrangements made according to the divorce decree before treatment begins.

Dental Insurance: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree the following:

- You must provide us with an insurance card and/or all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
- You are responsible to pay our fees; not what your insurance company allows or considers "usual, customary and reasonable"(UCR), all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Every effort will be made to help you with the insurance, including completing a Benefit Limitations Exception Form, but what is not covered is your responsibility.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
- Treatment provided at another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
- There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out of pocket expense will be.
- Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations. We reserve the right to withhold further treatment if there is an outstanding balance on your account.
- We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.
- **I have read and understand this document in its entirety; outlining the office and financial policies of Dental Surgeons and Associates and agree to these terms.**

*NEW POLICY EFFECTIVE 1/27/2023 *

- Appointments-
  Please call our office to confirm your appointment within 24 hours of your appointment time. If we do not hear from you, your appointment will be canceled and filled.
- Missed /Broken Appointments-
  After 3 missed/broken appointments, your next appointment will be scheduled at 8am. If you continue to show for 8 am appointments we will then schedule you at a later time in the day. If you fail to keep this you will be put on a permanent 8am schedule.

Signature of patient of parent/guardian: ______________________________

Date: ____________________