WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age:_____ SS #: _____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ Driver's License #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol / Drug Abuse	Y N	Herpes / Fever Blisters
Y N	Anemia	Y N	High Blood Pressure
Y N	Arthritis	Y N	HIV+ / AIDS
Y N	Artificial Bones / Joints / Valves	Y N	Hospitalized for Any Reason
Y N	Asthma	Y N	Kidney Problems
Y N	Blood Transfusion	Y N	Liver Disease
Y N	Cancer /Chemotherapy	Y N	Low Blood Pressure
Y N	Colitis	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Pacemaker
Y N	Diabetes	Y N	Psychiatric Treatment
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Emphysema	Y N	Rheumatic / Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sickle Cell Disease / Traits
Y N	Glaucoma	Y N	Sinus Problems
Y N	Hay Fever	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery	Y N	Ulcers
Y N	Hemophilia	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Metals
Y N	Codeine	Y N	Jewelry	Y N	Penicillin
Y N	Dental Anesthetics	Y N	Latex	Y N	Tetracycline

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter **teeth?** ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

Payment is due in full at the time of treatment unless prior arrangements have been approved.

!

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature **Date**

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ **Date:** _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____
2. Date: _____ Comments: _____ Signature: _____
3. Date: _____ Comments: _____ Signature: _____

Dr. David Freilich
Dr. Michael Rocheleau
Dr. Mark Forwood

FAMILY & COSMETIC DENTISTRY

Patient Financial Policy

Dr. Freilich and staff are committed to providing you with highest of quality dental care.

INSURANCE
As a courtesy to our patients, we will gladly file the forms necessary to see that you received the full benefits of your dental coverage. We ask that you read your policy to be fully aware of any limitations of the benefits provided. ***Please note: Many plans have frequency limitations pertaining to a number of the procedures done in our office. These limitations may change from benefit year to benefit year. If you are concerned about coverage for these services, please contact your insurance company prior to your visit.*** We accept all PPO plans and most union plans. Your clear understanding of your insurance plan and its limitations will help us and you the patient to know what your financial responsibility will be.

ESTIMATES
Our practice software enables us to estimate your insurance benefits after the dentist has diagnosed any necessary treatment. In cases where extensive dental treatment is recommended, we will submit a pre-authorization to your insurance company for an estimate of dental benefits. Regardless of estimated insurance coverage, any fees for treatment received, will be due at the time of service. In the case of a minor, the patient's accompanying adult, parent, or guardian is responsible for payment.

If payment from insurance has not been received after 30 days, the balance will be transferred to your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, covered charges, secondary insurance, ETC, other than to supply factual information as necessary. As the insurance policy holder, you are responsible for timely payment on your account.

DELINQUENT ACCOUNTS
An account is considered past due 30 days after the date of service unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency.

MISSED APPOINTMENTS
We would appreciate your help and the courtesy of a call if you are unable to keep your scheduled appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. We reserve the right to charge a missed appointment fee for each appointment that is not cancelled in a timely manner.

PAYMENT OPTIONS
For your convenience the following options are available:

- Cash or check (returned checks will be subject to a $30 returned check fee. If the check is returned for any reason, your account becomes due and payable within 7 days)
- Visa, Master Card, Discover, and American Express
- Care Credit

I HEARBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH, READ, AND UNDERSTAND THE PATIENT FINANCIAL POLICY STATED ABOVE

Patient/Guarantor Signature_____ Date_____

Family and Cosmetic Dentistry
David E. Freilich DMD
Michael D. Rocheleau DMD
Mark Forwood DMD

429 N. Springfield Rd. Clifton Heights, PA 19018
(610) 623-5151

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

Family and Cosmetic Dentistry makes every effort to ensure the privacy of your confidential medical and personal information. The information contained in our records will not be used or disclosed for marketing, research, fund-raising or other use without specific written authorization.

If you have authorized us to bill your insurance company for services rendered. Information necessary to process the claim will be submitted to your carrier either via US mail, fax, or electronic transmission. We will only submit information to carriers and clearinghouses that have agreed to protect your privacy accordingly.

We have altered our procedures so that in the event we must contact you by phone, no confidential information will be left on an answering machine or voice mail. We do not consider appointment dates and times confidential. We also reserve the right to send appointment notifications via cell phone and email.

In order to comply with HIPAA regulations and records transferred to another provider will require your authorization.

In the event that you wish a spouse or other family member or caregiver to have access to your records please notify us in the box below. Minor children's information will be available to the parents unless revoked by law. Basic dental information will be released to adults accompanying a minor to their appointment with permission from the parent. For example, if a grandparent or other caregiver brings the child we need permission to release information to them.

You may request a copy of the notice of privacy protection. In the event you believe your privacy has been compromised you have specific rights under the law. Information on the medical privacy law may be obtained through the U.S. Department of Health and Human Services office for Civil Rights.

Thank you.

_____ _____
Patient Signature (Parent or Guardian if patient is minor) Date

☐ Information can be released to: _____
Print Name

_____
Patient Signature (Parent or Guardian)