Warrington Dental Arts

**(267) 483-8351**

865 Easton Rd. Ste#110
Warrington, PA 18976

## *HOW DID YOU HEAR ABOUT US?*

☐ Friend/Family Member: Name_____ ☐ Sign/Walked-in ☐ Post Card Ads
☐ Internet Search ☐ Thru insurance ☐ Office Sign Other_____

## *PATIENT INFORMATION*

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Unspecified ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:_____ EMAIL:_____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext:_____
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th

Address: _____
Street Apartment #

_____
City State Zip Code

## *EMERGENCY CONTACT*

Name:_____ Relationship:_____

Phone (Cell): _____ (Work): _____ Ext:_____ Best time to call:

Address: _____
Street Apartment #

_____
City State Zip Code

## *MEDICAL HISTORY*

**Have you ever had any of the following? Please check those that apply:**

☐ HIV/AIDS
☐ Allergies _____
_____
_____
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Stomach Problems
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
_____
☐ Anemia
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

Are you pregnant? ☐Yes ☐No if yes, how many months? _____ Are you nursing? ☐ Yes ☐ No

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:_____

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

If yes, please explain:_____

Name of Physician: _____ Phone:_____

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

Please list each one:_____

_____

Do you smoke or use tobacco products? ☐ Yes ☐ No
Do you have any health condition's that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

## *DENTAL HISTORY*

What is the reason for your visit today? Check-up ☐ Cleaning ☐ Toothache ☐
Other:_____
_____
Are you interested in any of the following? Check all that apply:
___Straighter teeth (Invisalign) ___Botox / Fillers ___Teeth Whitening

Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____
Are you currently or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ☐ Yes ☐ No

Your current health : ☐ Good ☐ Fair ☐ Poor

Date of Last Dental Visit: _____

How many times a week do you floss?_____ Do you like your smile? Yes No
How many times a day do you brush?_____ Do you gum ever bleed? Yes No

***INSURANCE / DENTAL PLAN***

Primary insurance (circle one): PPO HMO
Plan Name: _____

Secondary insurance (circle one): PPO HMO
Plan Name: _____

**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 permission.**

_____ _____

Signature of patient, parent or guardian Date

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

# WARRINGTON DENTAL ARTS
# OFFICE POLICY

**INSURANCE POLICY:**

***YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOU AND YOUR INSURER.***
AS A COURTESY WE CHECK PATIENTS ELIGIBILTY AND ESTIMATE COPAYS IN OFFICE. IT IS YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND THE **TERMS**, **GUIDELINES**, AND **LIMITATIONS** OF YOUR PLAN. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES TO YOUR, ADDRESS, INSURANCE POLICY, OR CONTACT NUMBER. A CURRENT AND VAILD PHOTO ID & INSURANCE CARD IS REQUIRED, AND MUST BE PRESENTED AT EACH VISIT. IF ANY SERVICES FOR ANY REASON ARE NOT COVERED BY YOUR INSURANCE PLAN YOU WILL BE RESPONSIBLE FOR 100% OF BILLED CHARGES.

**CANCELLATIONS-MISSED APPOINTMENTS:**

***CANCELLATIONS AND MISSED APPOINTMENTS INCONVIENCE OTHER PATIENTS AND STAFF***. IF YOU NEED TO CANCEL YOUR SCHEDULED APPOINTMENT, WE REQUIRE AT LEAST **24 HOURS** CANCELLATION NOTICE. ANY MISSED APPOINTMENTS WILL RESULT IN A **$65.00** LATE FEE CHARGE. IF YOU ARE SCHEDULED FOR A ***SURGICAL OR COSMETIC PROCEDURE***, WE REQUIRE **48 HOURS** CANCELLATION NOTICE, FALIURE TO DO SO WILL RESULT IN A **$95.00** LATE FEE CHARGE.ALL LATE FEES MUST BE PAID BEFORE YOUR NEXT APPOINTMENT. FALIURE TO FOLLOWE THE MISSED APPOINTMENT POLICY MAY RESULT IN OFFICE DISSISMAL.

**PAYMENT:**
ALL CO-PAYS, CO-INSURANCE AMOUNTS, DEDUCTIBLES, AND NON-COVERED CHARGES ARE THE INSURED/PATIENT'S FINANCIAL RESPONSIBILTY, AND ARE DUE AT THE TIME OF YOUR APPOINTMENT. IF YOU ARE NOT PREPARED TO PAY YOUR OUT OF POCKET COST YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT. PAYMENTS SHOULD BE MADE WITH CASH,CREDIT CARD, OR MONEY ORDER.

**BALANCES**:
AS A COURTSEY TO OUR PATIENTS IF YOU HAVE A PAST DUE BALANCE YOU WILL RECIEVE INVOICE NOTICES AND PHONE CALL REMINDERS. IF YOUR BALANCE IS NOT PAID BY THE ASSIGNED DUE DATE AND YOU HAVE MADE NO ATTEMPT TO CONTACT THE OFFICE, YOUR ACCOUNT WILL BE TRANSFERED TO A THRID PARTY COLLECTION AGENCY.

**CHECK FEE**:
A FEE OF $25.00 WILL BE CHARGED FOR ANY CHECK'S RETURNED DUE TO INSUFFICENT FUNDS.

**I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS OF THE OFFICE POLICY(S).**

X_____ (PRINT NAME)

X_____ (PATIENT/GUARDIAN SIGNITURE)

X_____ (DATE)