

Dentistry On The Hill

427 Shadeland Avenue • Drexel Hill, PA 19026

(610)259-5369

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
City State Zip Code

Preferred appointment times:

Mon Tue Wed Thur Fri Sat Morning Afternoon Evening Any time

Whom may we thank for referring you to our practice?

Dental Office Yellow Pages Internet Newspaper School Work
 Other (name below):

Name of person, office, or other source referring you to our practice:

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____

Address 1

Address 2

City

State

Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient:

Response Date: ____/____/____

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Medical & Dental History Form

Patient Name: _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? Yes No

Within the past year, have there been any changes in your general health? Yes No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Are you currently taking any prescription or non-prescription medications?
- Do you use tobacco (smoking or chewing)?
- Do you require the use of corrective lenses (contacts or glasses)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant? Yes No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | | |

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

- 3 (+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

- 1 (+) a day 2 - 6 weekly 1 - 6 monthly Seldom Never

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
 Do your teeth experience sensitivity to cold or hot temperatures?
 Are any of your teeth currently causing you pain?
 Do you grind your teeth (either consciously or during sleep)?
 Are any of your teeth loose, or are you concerned about any teeth loosening?
 Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be? *

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ Date _____

Relationship to Patient:

Response Date: ____/____/____



FINANCIAL AGREEMENT FOR AARON UFBERG, DMD

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Print Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date