PATIENT INFORMATION

Last Name **First Name** **M.I.** **Preferred Name:**

_____

Address

_____

City **State** **Zip**

_____

Home Phone **Cell Phone** **Work Phone**

(_____)_____(_____)_____(____)_____

Email

_____

Birthdate **Social Security #** **Male** ◯ **Female** ◯

_____

Married _____ Single ____ Divorced _____ Widowed _____

Occupation **Employer's Name**

_____

How were you referred to our office?

Emergency Contact:

Name: **Phone Number:**

_____

ACCOUNT INFORMATION

Person Financially Responsible for Account: **Check if same as patient** ◯

Name **Relationship to Patient**

Birthdate **Social Security #**

_____

Address

_____

City **State** **Zip**

_____

Home Phone **Cell Phone** **Work Phone**

(_____)_____(_____)_____(____)_____

DENTAL INSURANCE

Primary Carrier:

Insurance Company_____

Group Number_____

Insured's Name_____

Insured's Birthdate_____

Insured's ID / SSN_____

Secondary Carrier:

Insurance Company_____

Group Number_____

Insured's Name_____

Insured's Birthdate_____

Insured's ID / SSN_____

Financial Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians are responsible for full payment at time of service.

INSURANCE

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 a contract between you, your employer, and your insurance company.

Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT

We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing (Care Credit) at the time we provide the service to you.

CONSENT for TREATMENT

- **I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.**

- **Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed up on by me and to employ such assistance as required to provide proper care.**

- **I agree to use of anesthetics as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.**

- **I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.**

Signature of Patient, Parent or Guardian:_____

Release of Records

I authorize the release of records and x-rays relevant to dental treatment and request that they be sent to **Abington Family Dentistry, P.C.**

Address: 314 N. State Street, Clarks Summit, PA 18411

Fax: 570-586-5857

Email: abingtonfamilydentistry@frontier.com

Phone: 570-586-6500

Patient's Name: _____

Date of Birth_____

Signature_____

Today's Date_____

DENTAL HISTORY

Date of Last Dental Visit: _____

Last Dental Cleaning: _____

Last Full Mouth Xrays: _____

What was done at your last dental visit?_____

Previous Dentist's Name_____ Telephone:_____

Address:_____State_____Zip_____

How often do you have dental exams?_____

How often do you brush your teeth? _____

How often do you floss? _____

What other dental aids do you use? (ie: toothpick, stimudent) _____

Do you have any dental problems now? _____

Dental Conditions - Please check all that apply:

Sensitivity to:

Hot ____ Cold ____ Chewing ____ Sweets ____

Clench / grind your teeth while awake or asleep____

Jaw Issues: Pain ____ Clicking ____ Tired ____

Difficulty opening/closing your mouth ____

Earaches ____

Bite your lips or cheeks regularly ____

Snore / sleeping disorders? ____

Hold foreign objects with your teeth (pencils, pipe, etc) ____

Mouth breathe while awake or asleep ____

Dental Anxiety ____

Tobacco Use:

Smoke ____ Chew ____ Vape ____

Broken teeth ____

Fingernail biting ____

Tooth pain ____

Loose teeth ____

Food caught in between teeth ____

Gums hurt / bleed ____

Smoke/Chew Tobacco ____

Head / Shoulder / Neck Pain ____

Mouth sores / growths ____

Have you ever had:

Orthodontic treatment _____

Oral surgery _____

Periodontal treatment _____

Your teeth ground or the bite adjusted _____

A bite plate or mouth guard _____

A serious injury to the mouth or head _____

Dental Implants _____

Are you satisfied with your teeth's appearance?

Would you like to replace your silver fillings? _____

Would you like to keep all your teeth all of your life? _____

MEDICAL HISTORY

Physicians Name: _____Phone_____

Have you had any medical care within the past two years? _____

_____

Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? _____

_____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? _____

Have you been a patient in the hospital during the past five years? _____

_____

Have you ever been told to take an antibiotic pre-medication prior to dental treatment? (Due to joint replacement or cardiac issues?) Yes_____ No_____

Are you allergic to any of the following?

Aspirin ____	Ibuprofen ____	Morphine ____	Sulfa Drugs ____	Acrylic _____
Metal ____	Penicillin ____	Codeine ____	Epinephrine ____	Local Anestetics _____

Other? _____

Women - Are you:

Pregnant / Trying to get pregnant? ____ Nursing ____ Taking oral contraceptives ___

Indicate which of the following you have had, or have at present check all that apply:

Acid Reflux	____	Excessive Bleeding	____	Osteopenia	____
AIDS/HIV Positive	____	Excessive Thirst	____	Osteoporosis	____
Alzheimer's	____	Fainting Spells/Dizziness	____	Pain in Jaw Joints	____
Anaphylaxis	____	Frequent Cough	____	Parathyroid Disease	____
Anemia	____	Frequent Diarrhea	____	Psychiatric Care	____
Angina	____	Frequent Headaches	____	Radiation Treatments	____
Arthritis	____	Genital Herpes	____	Recent Weight Loss	____
Artificial Heart Valve	____	Glaucoma	____	Renal Dialysis	____
Artificial Joint(s)	____	Hay Fever	____	Respiratory Disease	____
Asthma	____	Heart Attach/Failure	____	Rheumatic Fever	____
Autoimmune Disease	____	Heart Murmur	____	Rheumatism	____
Blood Disease	____	Heart Pacemaker	____	Scarlet Fever	____
Blood Transfusion	____	Heart Trouble / Disease	____	Shingles	____
Breathing Problems	____	Hemophilia	____	Sickle Cell Disease	____
Bruise Easily	____	Hepatitis A	____	Sinus Trouble	____
Cancer	____	Hepatitis B or C	____	Sleep Apnea	____
Chemotherapy	____	Herpes	____	Spina Bifida	____
Chest Pains	____	High Blood Pressure	____	Stents	____
Chronic Cough	____	High Cholesterol	____	Stomach/Intestinal Disease	____
Circulatory Problems	____	Hives or Rash	____	Stroke	____
Cold Cores/Fever Blisters	____	Hypoglycemia	____	Swelling of Limbs	____
Congenital Heart Disorder	____	Irregular Heartbeat	____	Thyroid Disease	____
Convulsions	____	Kidney Disease	____	Tonsillitis	____
Cortisone Medicine	____	Latex Sensitivity	____	Transplant(s)	____
Depression	____	Leukemia	____	Tuberculosis	____
Diabetes	____	Liver Disease	____	Tumors or Growths	____
Drug Addiction	____	Low Blood Pressure	____	Ulcers	____
Easily Winded	____	Lung Disease	____	Venereal Disease	____
Emphysema	____	Mitral Valve Prolapse	____	Yellow / Jaundice	____
Epilepsy or Seizures	____	Neurological Disorders	____		

Have you ever had any serious illness not listed above?

_____