Colonial DENTAL Group

4940 Linglestown Road Harrisburg, PA 17112

Phone: 717-901-7045

Fax: 717-657-2712

New Patient Forms

Patient Registration **Today's Date** _____

First Name _____ Last Name_____ MI ____ Date of Birth_____Age____

Sex M or F Soc. Sec. # _____ **Please Circle One:** Single Married Separated Widow

Mailing Address _____ City _____ State ____ Zipcode ____

Physical Address _____ City _____ State ____ Zipcode ____

Email _____ Home Phone (_____)_____ Cell (____)_____

Drivers License # _____ Employer _____

Work Phone (____)_____ Occupation _____

Are you a full time student? Yes or No

If patient is a minor: Mother's DOB _____ Father's DOB_____

Name or Parent _____ Parent Soc. Sec. # _____

Person Responsible for Account _____ Relationship _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's Visit? _____

Dental Insurance Information (Primary)

Insured's Name _____

Insured's ID Number _____

Insured's Employer _____

Insured's DOB _____

Insurance Co. _____

Group # _____ Local # _____

Dental Insurance Information (Secondary)

Insured's Name _____

Insured's ID Number _____

Insured's Employer _____

Insured's DOB _____

Insurance Co. _____

Group # _____ Local # _____ Rank ___

Our office does NOT know this insurance is Primary. It is your responsibility to know your insurance coverage. Claims NOT paid due to incorrect information will result in patient paying entire balance.

Colonial Dental Group – Patient Health History

Patient's Name **Age** **Date**

Medical Doctor _____ Referring Dentist_____Orthodontist_____
Medical Specialist/s _____

Answer all questions. Check √ Yes or No **All responses are kept confidential**

01. Do you have specific dental problem/s? ..... Yes ☐ No ☐
    Describe:_____
02. Do you have dental exams on a regular basis? ..... Yes ☐ No ☐
    If so, when was your last visit? _____
03. Do you think you have active decay or gum disease? ..... Yes ☐ No ☐
04. Do you brush and floss on a regular basis? ..... Yes ☐ No ☐
05. Do your gums bleed? ..... Yes ☐ No ☐
06. Do you like your smile? ..... Yes ☐ No ☐
07. Does food catch between your teeth? ..... Yes ☐ No ☐
08. Do you ever have clicking, popping or discomfort in the jaw joint? ..... Yes ☐ No ☐
09. Do you clench or grind your teeth? ..... Yes ☐ No ☐
10. Do you smoke or chew tobacco, or its products? ..... Yes ☐ No ☐
11. Are there any sores or growths in your mouth? ..... Yes ☐ No ☐
12. Name of previous dentist (Optional): _____
13. Date of last full mouth x-rays (18 small films or panoramic):_____
14. Are you in good health? ..... Yes ☐ No ☐
15. Has there been any change in your general health in the past year? ..... Yes ☐ No ☐
16. Date of last physical exam _____
17. Are you now under a physician's care for a particular problem? ..... Yes ☐ No ☐
18. Have you **ever** had any serious illnesses, operations, or hospitalizations? ..... Yes ☐ No ☐
    If so, describe:_____
    _____
19. Do you have any permanent or temporary physical condition that would prevent you from sitting in a dental chair? ..... Yes ☐ No ☐
    If yes, elaborate: _____
20. **(OPTIONAL)** What is your height?_____ What is your weight?_____

21. **DO YOU HAVE OR HAVE YOU EVER HAD:**
    - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Yes ☐ No ☐
    - B. Congenital Heart Disease? ..... Yes ☐ No ☐
    - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Yes ☐ No ☐
    - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Yes ☐ No ☐
      If Yes, specify:_____
      _____
    - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Yes ☐ No ☐
    - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Yes ☐ No ☐
    - G. Liver Disease (Jaundice, Hepatitis)? ..... Yes ☐ No ☐
    - H. Kidney Disease? ..... Yes ☐ No ☐
    - I. Diabetes? ..... Yes ☐ No ☐
    - J. Thyroid Disease (Goiter)? ..... Yes ☐ No ☐
    - K. Arthritis? ..... Yes ☐ No ☐
    - L. Stomach Ulcers or Colitis? ..... Yes ☐ No ☐
    - M. Glaucoma? ..... Yes ☐ No ☐
    - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Yes ☐ No ☐
    - O. Radiation treatment for Cancer? ..... Yes ☐ No ☐
    - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Yes ☐ No ☐
    - Q. Sinus or nasal problems? ..... Yes ☐ No ☐
    - R. Exposure to the HIV or AIDS virus? ..... Yes ☐ No ☐
    - S. Any disease, drug, or transplant operation that has depressed your immune system? ..... Yes ☐ No ☐

Health History

Answer all questions. Check √ Yes or No **All responses are kept confidential**

22. **Are You Using Any of the Following:**

A. Antibiotics?	Yes ☐	No ☐
B. Anticoagulants (Blood Thinners)?	Yes ☐	No ☐
C. Aspirin or drugs such as, Motrin, Aleve, Ibuprofen?	Yes ☐	No ☐
D. High Blood Pressure medications?	Yes ☐	No ☐
E. Steroids (Cortisone, etc.)?	Yes ☐	No ☐
F. Tranquilizers?	Yes ☐	No ☐
G. Insulin or Oral Anti-Diabetic drugs?	Yes ☐	No ☐
H. Digitalis, Inderal, Nitroglycerin or other heart drug?	Yes ☐	No ☐
I. Bisphosphonates (for osteoporosis. Multiple myeloma or other cancers), such as Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, or Prolia.	Yes ☐	No ☐

J. Please list any and all medications taken, including prescription medications, over-the-counter medications herbal/holistic remedies, vitamins or minerals:

_____

_____

_____

23. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novocain, etc.)?	Yes ☐	No ☐
B. Penicillin or other antibiotics?	Yes ☐	No ☐
C. Sedatives, Barbiturates?	Yes ☐	No ☐
D. Aspirin or Ibuprofen?	Yes ☐	No ☐
E. Codeine or other pain killers?	Yes ☐	No ☐
F. Latex or Rubber products?	Yes ☐	No ☐
G. Other allergies or reactions?	Yes ☐	No ☐

Please List: _____

_____

24. Do you smoke or chew tobacco?	Yes ☐	No ☐
How much per day? _____ How many years? _____		
25. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?	Yes ☐	No ☐
26. Have you had any serious problems associated with any previous dental treatment?	Yes ☐	No ☐

If yes, please elaborate: _____

_____

27. Have you or an immediate family member had any problem associated with intravenous anesthesia?	Yes ☐	No ☐
28. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?	Yes ☐	No ☐
29. Doyou wish to talk to the doctor privately about anything?	Yes ☐	No ☐

30. For WOMEN Only:

A. Are you pregnant, or is there any chance you might be pregnant?	Yes ☐	No ☐
B. Are you nursing?	Yes ☐	No ☐

C. **If you are using Oral Contraceptives**, it is **important** that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication in completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I will have the opportunity to discuss my Health History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

ASSIGNMENT OF BENEFITS AGREEMENT FOR COLONIAL DENTAL GROUP

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. Itis important to understand though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 15 days from the time of billing. If your insurance company has not made payment to our practice within 30 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our Practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort our any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

- All family balances / patient balances must be paid in full before other services are rendered. If payment cannot be obtained PRIOR to any patient / family appointments our office will reschedule your appointment until the balance is paid. ALL balances will be collected in full prior to patient going back for services.
- It is the patient / Guarantor's responsibility to inform the office to remove any adult children off their account. All balances on account / claims must be paid in full prior to removing patients off accounts.

SERVICE CHARGE: If I do not pay the entire new balance within **60 days** of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of **1.5%** per month. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. **Initial** _____

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE AVOBE POLICIES. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

Signature of Patient or Responsible Party **Date**

Appointment Confirmation Policy

Your appointment is *reserved exclusively for you*. Our office sends confirmation alerts via text, email and courtesy calls. We ask that you confirm your appointment by one of our forms of communication.

Failure to confirm your appointments could result in your appointment being rescheduled.

Please confirm appointments at **minimum 1 day prior** to your appointment to avoid cancellation.

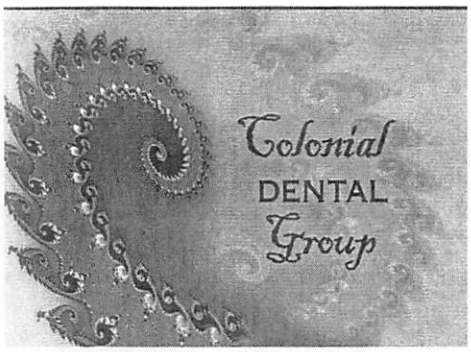
Continual non confirmation could result in dismissal from the practice.

Confirmation of appointments and then failure to show will result in a **$75 charge**. If you need to make changes to your appointment please call the office 24 hours in advance.

Our office strives to ensure the best care for our patients and in order to serve all of our patients we ask that you please confirm appointments.

I have read and accept the confirmation policy of Colonial Dental Group.

Printed Name Signature of Patient/ Guardian Date



4940 Linglestown Road

Harrisburg, PA 17112

717-901-7045

BROKEN APPOINTMENT POLICY

Our goal is to provide quality dental care to all of our patients. In order to do so, we have implemented the following cancellation policy at our office. This policy allows us to better use available appointments for our patients in need of dental care.

When you schedule an appointment, we reserve that time exclusively for you. If you do not show up for your appointment, it prevents another patient from being seen for needed treatment.

HOW TO CANCEL YOUR APPOINTMENT

We understand that there may be times when you must miss an appointment due to emergencies or obligations for work or family. If you need to cancel your appointment, **please call us at (717) 901-7045 with at least 24 hours notice in advance**. If necessary, you may leave a message with your name and phone number. A receptionist will get back with you as soon as possible.

Additionally, if you are 10 minutes past your scheduled time, we may have to reschedule your appointment.

CANCELLATION FEE If you miss a scheduled appointment without informing us within 24 hours, we will apply a $75 fee to your account for each missed appointment.

CONFIRMATION & NO SHOW If you confirm an appointment and cancel and/or do not show up for your appointment, we will apply a $75 fee to your account for each missed appointment.

DISMISSAL We reserve the option to dismiss you as a patient if you miss three (3) appointments in a one-year period without a 24 hour notice under this policy.

Patient Name:_____

Signature/Parent/Guardian:_____

Date:_____

Signature On File

Patient Name: _____

PLEASE READ THE FOLLOWING STATMENTS.

THEN SIGN AND DATE BELOW ACKNOWLEDING YOUR UNDERSTANDING.

I authorize the use of this form on all my insurance submissions.

I authorize the release of the information to all of my insurance companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I permit a copy of the authorization to be use in place of the original.

I understand benefits checked are not a guarantee of payment.

Signature: _____

Date: _____

HIPAA PRIVACY AUTHORIZATION FORM Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

Name of parent or guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or directed below. The purpose of this request is for personal reasons.

2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in section 3 in order to be able to process claims with the insurance company and/or for personal reasons.

3. In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my/my spouse or domestic partner/my dependent's billing, condition, treatment and prognosis to the following individual(s) (please caregivers that may accompany children to appointments):

Name _____ **Relationship** _____
Name _____ **Relationship** _____
Name _____ **Relationship** _____

4. This medical information may be used by the persons I authorize to receive this information for dental/medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and in effect 1 year from signed date.

6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation.

7. I understand that my dental provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Messages

Please call ( ) my home ( ) my work ( ) my cell number: _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

Signed: _____ **Date:** ____/____/____
Parent/Guardian: _____ **Date:** ____/____/____

Informed Consent to Treatment

Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

(Initial:)

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed.

(Initial:)

X-Rays

I understand x-rays are necessary for proper diagnosis and treatment. **(Initial:)**

Fillings

I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage.

I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed filling.

(Initial:)

Local Anesthetic

Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment.

(Initial:)

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I consent to the proposed treatment. (Initial:)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.

3. In general terms, the dental procedure(s) can include is not limited to:

   a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride

   b. Application of resin "sealants" to the grooves of the teeth

   c. Treatment of diseased or injured teeth with dental restorations (fillings)

   d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections

4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

7. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____

Patient Name (Print)

_____

Patient or Parent / Guardian Signature

_____

Date

Emergency Contact & Patient Pharmacy

Your Name: _____, _____, _____

Last First MI

Home Phone: (___) _____ Cell: (__) _____ Work: (____) _____

Address: _____

Street City State

Emergency Contact Name: _____

Home Phone: (___) _____ Cell: (__) _____ Work: (____) _____

Address: _____

Street City State

If unavailable **(2nd) Contact Name:** _____

Home Phone: (___) _____ Cell: (__) _____ Work: (____) _____

Address: _____

Street City State

Preferred Local Hospital: _____

Comments: Please include any special medical or personal information you would want an emergency care provider to know –or special contact information.

_____

_____

_____

_____

If we would need to call in a prescription for you please list your preferred Pharmacy.

Pharmacy Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Acknowledgement of Privacy Practices

ACKNOWLEDGEMENT FORM

I have received the **"Notice of Privacy Practices"** and have been provided an opportunity to review it.

Notice of Privacy Practices" is displayed at the check in window. A physical copy to keep will be provided upon request.

Patient Name (Print)	Patient Date of Birth
Parent | Guardian Name if Patient is a Minor (Print)	Relationship to Patient
Signature	Date