Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone (____) _____ Alt. Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Sides

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me 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.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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

Patient Consent Form

Judith R.T. Shaffer, DMD, PC
20 Prospect Avenue
West Grove, PA 19390
610-869-0555

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

I give permission for this office to share my protected health information with the following: _____

_____

Signature: _____ Date: _____

FINANCIAL POLICY

Dr. Judith R. Shaffer D.M.D. is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding if our financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE CLINICIAN.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, CARE CREDIT AND CITIHEALTH CARD.

ADULT PATIENTS

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

MINORS ACCOMPANIED BY AN ADULT

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

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at the time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, MasterCard or Care Credit.

INSURANCE

Dr. Judith R. Shaffer D.M.D provides insurance company billing as a *courtesy* to our patients. The patients portion of particular dental service (s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, most insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for full payment of that amount. The patient is responsible for keeping track of remaining benefits with his/her dental insurance company and cannot rely on a Dr. Judith R. Shaffer D.M.D staff member.

The claims we submit to insurance companies usually indicate that you have assigned those benefits to Dr. Judith R. Shaffer D.M.D. However, if you are paid directly by the insurance company instead of the insurance company releasing payment to Dr. Judith R. Shaffer D.M.D, you then become responsible for the entire fee at the time of service. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available from both insurances, but your balance is expected after 1st insurance company pays. You as a patient are always responsible for any charges that are not covered by your insurance.

MISSED APPOINTMENTS

Please help us serve you better by keeping your scheduled appointments and to get your needed dental work done. Your scheduled time is reserved especially for you; changes in the schedule affect our work, staff and other patients. Accounts will be charged the following below for appointments:

$50.00 for any **NO SHOW APPOINTMENT**
$25.00 for **SAME DAY CANCELATION**
$75.00 for **SATURDAY CANCELATION**

We understand that sometimes it might be difficult to keep your appointment. Please, if you need to reschedule your appointment, we would appreciate a call as early as possible (at least 24-48 hrs in advance for Doctor and staff time).

Thank you for your understanding.

Please let us know if you have any questions or concerns.

Responsible Party Signature _____ ***Date*** _____