Welcome

Thank you for selecting our dental health team.
We look forward to working with you in maintaining your dental health.

Date ____/____/____

Patient's Name ____
Last First M.I.

Address ____

City ______________________________ State ___________ Zip Code _________

Home Phone (____) __________________ Work Phone (____) __________________

Cell Phone (____) ____________________ Email address ______________________

Date of Birth ____/____/____ Social Security # _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Person to Contact in Case of an Emergency __________________________________

Their Home Phone (____) ______________________

Preferred Contact Method:

□ Home □ Work □ Cell □ Text Message □ Email

***Whom may we thank for referring you to our office? _________________________

INSURANCE INFORMATION

(If you are the subscriber of the account, only fill out the first two questions.)

Name of Insurance ____

Group Number _____________________

Name of Subscriber ____

Name of Employer ____

Is this form for □ Spouse □ Child

Subscriber's Social Security # _____-_____-_____

Subscriber's Date of Birth ____/____/____

Do you have secondary insurance? □ Yes □ No

Name of Insurance ____

Group Number _____________________

Subscriber's Social Security # _____-_____-_____

Name of Employer ____

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Scanned Insurance Card? □ Yes □ No

Medical History

1. Are you in good health? □ Yes □ No If no, please explain_______________________________________
2. Are you under a physician's care now? □ Yes □ No
   If yes, please give reason for treatment ____
3. Name of Your Physician _________________________ Address _________________________________
4. Has there been any recent change in your general health? □ Yes □ No
   If yes, please explain ____
5. Last exam date with your family physician ____/____/____
6. Are you taking any medications at this time? □ Yes □ No
   If yes, please list ____
   ____
7. Please check any illnesses you have had or presently have:

□ Allergies	□ Glaucoma	□ Diabetes	□ Heart Valve (leaking or defective)
□ Psychiatric	□ Tuberculosis	□ Low Blood Pressure	□ High Blood Pressure
□ HIV Positive	□ AIDS	□ Hepatitis	□ Rheumatic Fever
□ Pace Maker	□ Multiple Sclerosis	□ Lung Conditions	□ Joint Replacement
□ Asthma	□ Epilepsy	□ Heart Trouble	□ Kidney/Liver Problem

8. Are you allergic to any of the following?

□ Aspirin	□ Penicillin	□ Codeine	□ Acrylic
□ Metal	□ Latex	□ Sulfa Drugs	□ Local Anesthetics

9. Do you have any condition not listed above that you think we should know about? □ Yes □ No
   If yes, please explain ____
10. Do you have any trouble with prolonged bleeding? ____
11. Do any family members have diabetes? □ Yes □ No
12. Do you smoke? □ Yes □ No If yes, how much? ____
13. Do you use smokeless tobacco? □ Yes □ No If yes, how much and how long? ______________________
14. What is the name of your water company? ____

I, the undersigned, do affirm that the above information is correct and do give consent to agreed upon dental service, and use of appropriate methods thereto.

Patient or Parent/Guardian Signature: ____________________________________ **Date**: ____/____/____

Dental Health

1. When was your last dental visit? ____
2. Name of your previous dentist? ______________________ Address _______________________________
3. Does your child take fluoride at home? □ Yes □ No
4. What is your dental preference?

   □ Local Anesthetic (Novocain) □ No anesthetic □ Relative Analgesia (Nitrous Oxide)

   □ Oral Pre-Medication □ I.V. Sedation
5. Have you ever had any unfavorable reaction from previous medical or dental care? □ Yes □ No

   If yes, please explain ____
6. Have you ever had periodontal disease? □ Yes □ No
7. Are you pleased with the appearance of your teeth? □ Yes □ No

   If no, why? ____
8. Are you in pain now? □ Yes □ No If yes, where? ____
9. Do your gums bleed? □ Yes □ No If yes, please explain ____
10. Do your teeth feel loose? □ Yes □ No If yes, please explain _____________________________________
11. Do you grind or clench your teeth during the day or night? □ Yes □ No
12. Do you have sore or sensitive teeth? □ Yes □ No If so, is it to: □ sweets □ hot □ cold
13. Do you have pain elsewhere in your face or jaws? □ Yes □ No

    If yes, where? ____
14. Does food collect between your teeth? □ Yes □ No
15. Do you think you have bad breath? □ Yes □ No

I, the undersigned, do affirm that the above information is correct and do give consent to agreed upon dental service, and use of appropriate methods thereto.

Patient or Parent/Guardian Signature: ______________________________________ **Date**: ____/____/____

Financial Responsibility

Date: ____/____/____

Patient's Name: ____

Address: ____ Phone: (____) _____________

I hereby agree to pay Dr. Warren D. Silvers, D.M.D. for professional services rendered. I understand that I am responsible for the entire amount due, payable at the time of services unless prior financial arrangements have been made.

If there is dental insurance, then services will be billed to the carrier as a courtesy and all monies received will be credited to my account. I am responsible for any charges, processing delays or other circumstances. All unpaid charges will be reflected on a monthly statement. We reserve the right to attach finance charges on any balance over 30 days old.

I understand that when appropriate, credit bureau reports may be obtained. I am responsible for co-payment and /or deductibles at the time of service.

Patient or Parent/Guardian Signature: _________________________ **Date**: ____/____/____

Insurance Signature on File

(Sign only if you have insurance)

The benefits payable under the below named insurance policy have been assigned to:
Warren D. Silvers, D.M.D., 4392 Sturbridge Drive, Harrisburg, PA 17110.

Authorization to pay benefits directly to the Dentist:
I hereby authorize payment directly to Warren D. Silvers, D.M.D. for all dental benefits entitled to me for dental treatment. I understand that I am financially responsible for all charges not covered by this assignment for any reason.

Insurance Company's Name: ____

Authorization to release information:
I hereby authorize Dr. Silvers to release any information acquired in the course of my examination or treatment to the above named insurance company, or to any dentist to whom I am referred.

Patient or Parent/Guardian Signature: _________________________**Date**: ____/____/_____

Silvers Family Dental Care
Late Arrival, Cancellation and Missed Appointment Policy

Our office is dedicated to providing all of our patients with the most thorough and comfortable dental care available. We know that efficient scheduling is an important part of the dental office experience. Therefore, we have comprised a NEW office policy regarding late arrivals, cancelled appointments and missed appointments.

The following guidelines went into effect **March 1, 2012**:

1. **On time arrival**
   Please arrive a few minutes before your scheduled appointment time.

2. **Late Arrival**
   We respect our patients' time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could delay us. If we are significantly delayed, every effort will be made to notify you beforehand. In turn, if you are running late, we ask that you please notify us. If you are significantly delayed, your scheduled treatment may be modified or you may be asked to reschedule your appointment.

3. **Cancellation**
   We do require a 48 hour notice for all changes to scheduled appointments. If 48 hour notice is not given, we reserve the right to apply a broken appointment fee to your account.

4. **Missed Appointment**
   It is extremely important that all patients honor their dental appointments. Therefore, all patients who fail to arrive for their scheduled appointments will be charged for a broken appointment.

Our broken appointment fee is **$60 per appointment**; this fee is subject to change. If a broken appointment fee has been applied to your account, the fee must be paid prior to rescheduling.

Please note: As a courtesy to you, we will make every effort to remind you of your scheduled appointment. If our attempts are unsuccessful, it is still your responsibility to keep your scheduled appointment or to contact us 48 hours in advance to change or cancel your appointment.

We feel these guidelines are reasonable in relation to the services we provide. We do understand that circumstances occur that will require our consideration. Any questions are always welcome.

I, the undersigned, understand and agree to the late arrival, cancellation, and missed appointment policy.

Patient or Parent/Guardian Signature: __________________________ **Date**: ____/____/____

Patient Authorization and Release Form

Photo Consent Form

I hereby give Silvers Family Dental Care and any and all employees and/or agents of Silvers Family Dental Care the right and permission to use and/or publish photographs of me for art, promotional and educational purposes (including but not limited to, advertising, publicity, commercial or display of use).

Release of Claims:

I hereby release and discharge Silvers Family Dental Care and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Initial the following:

______ Yes, you may use my photos
______ No, please do not use my photos

Patient or Parent/Guardian Signature: __________________________ **Date**: ____/____/____

Silvers Family Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

By signing this form you are stating that you have received a copy of this office's Notice of Privacy Practices.

____

Patient's Name (Please Print)

____

Patient or Parent/Guardian Signature

____

Date

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) ____________________________