WELCOME TO QUAKERTOWN FAMILY DENTAL CENTER

NAME__________________ BIRTHDATE __________ MARITAL STATUS________ SS# ________

HOME ADDRESS:__________________ CITY: __________ STATE:______ ZIP: ________

HOME PHONE: (   ) __________ BUSINESS PHONE: (   ) __________ EMPLOYER:__________

CELL PHONE: (   ) __________ EMAIL: __________________

EMP. ADDRESS: __________________ CITY: __________ STATE:______ ZIP:________

PRIMARY DENTAL INS.:__________________________________

SUBSCRIBER __________________ SS# __________ BIRTHDATE__________

ID# __________________ GROUP# __________ EMPLOYER:__________

RELATIONSHIP TO PATIENT:__________________________________

SECONDARY DENTAL INS: __________________________________

SUBSCRIBER:__________________ SS# __________ BIRTHDATE:__________

ID# __________________GROUP#: __________ EMPLOYER:__________

RELATIONSHIP TO PATIENT:__________________________________

PERSON RESPONSIBLE FOR DENTAL BILLS: __________________________________

PATIENT DENTAL HISTORY

LAST DENTAL VISIT: __________________________

LAST DENTAL CLEANING: __________________________

HAVE YOU HAD DENTAL X-RAYS__________________________

WITHIN 3 YEARS: __________________________

IF SO, WHEN: __________________________

NAME & ADDRESS OF PREVIOUS DENTIST:

____

____

____

____

HOW OFTEN DO YOU BRUSH YOUR TEETH: __________________________

YES	NO	
☐	☐	HAVE YOU HAD BROKEN TEETH/ FILLINGS?
☐	☐	IF SO, WERE THEY REPAIRED?
☐	☐	HAVE YOU HAD TEETH EXTRACTED?
☐	☐	IF SO, WERE THERE COMPLICATIONS?
☐	☐	WERE MISSING TEETH REPLACED?
☐	☐	IF SO, BY PARTIALS OR DENTURES
☐	☐	BY BRIDGES
☐	☐	BY IMPLANTS
☐	☐	WOULD YOU LIKE MISSING TEETH REPLACED?
☐	☐	DO YOU HAVE PAIN IN OR AROUND YOUR EARS?
☐	☐	ARE YOU UNHAPPY WITH YOUR TEETH (SHAPE, COLOR, ALIGNMENT, ETC)? IF SO, WHAT WOULD YOU LIKE TO CHANGE?

____

YES	NO	
☐	☐	HAVE YOU HEARD OF DENTAL IMPLANTS?
☐	☐	WOULD YOU LIKE MORE INFORMATION ON IMPLANTS?
☐	☐	DO YOUR GUMS BLEED?
☐	☐	DO YOU FEEL YOU HAVE BAD BREATH OR AN UNPLEASANT TASTE?
☐	☐	HAVE YOU HAD PERIODONTAL (GUM) TREATMENT?
☐	☐	DO YOU GRIND OR CLENCH YOUR TEETH?
☐	☐	DO YOU HEAR POPPING OR CLICKING IN IN YOUR JAW
☐	☐	HAVE YOU BEEN DIAGNOSED WITH TMJ DISORDER?
☐	☐	DO YOU HAVE ANY UNTREATED INJURIES, GROWTHS OR SORE SPOTS IN YOUR MOUTH?

(OTHER SIDE PLEASE)

PATIENT MEDICAL HISTORY

YES	NO	
☐	☐	ARE YOU CURRENTLY IN GOOD HEALTH?
☐	☐	HAVE YOU HAD ANY MAJOR OPERATIONS? IF SO, WHAT ______
☐	☐	HAVE YOU HAD INJURIES INVOLVING YOUR HEAD OR JAWS?
☐	☐	HAVE YOU HAD ANY ADVERSE REACTION TO DRUGS INCLUDING PENICILLIN AND ASPIRIN?

IF SO, LIST ______

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ HEART AILMENT, MURMUR, SURGERY
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ RESPIRATORY DISEASE
- ☐ DIABETES
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ TUMOR/GROWTHS
- ☐ USE OF TOBACCO
- ☐ BLOOD DISEASE
- ☐ LIVER DISEASE
- ☐ KIDNEY DISEASE
- ☐ STOMACH/INTESTINAL DISEASE
- ☐ VENERAL DISEASE
- ☐ YELLOW JAUNDICE/HEPATITIS
- ☐ EPILEPSY
- ☐ AIDS/HIV+
- ☐ RADIATION/COBALT TREATMENT
- ☐ GLAUCOMA
- ☐ CHEMOTHERAPY
- ☐ THYROID DISEASE
- ☐ PSYCHIATRIC THERAPY

YES	NO	
☐	☐	ARE YOU CURRENTLY ON A DIET?
☐	☐	ARE YOU ALLERGIC TO ANY KNOWN MATERIALS RESULTING IN HIVES, ASTHMA, ECZEMA, ETC.? IF SO, WHAT ______
☐	☐	ARE YOU PREGNANT?
☐	☐	DO YOU HAVE A HISTORY OF FAINTING?
☐	☐	HAVE YOU RECEIVED ANY DONOR ORGANS, ARTIFICIAL HEART VALVES, VESSELS, JOINT IMPLANTS?
☐	☐	DO HAVE A PACEMAKER?
☐	☐	ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF SO, PLEASE LIST

MEDICATION	REASON
______	______
______	______

NAME OF YOUR MEDICAL DOCTOR ______

I CERTIFY THAT THE ANSWERS GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND (IF APPLICABLE) GIVE PERMISSION FOR MY INSURANCE COMPANY TO SEND PAYMENTS DIRECTLY TO QUAKERTOWN FAMILY DENTAL CENTER.

______ Signature

______ Date

Quakertown Family Dental Center

280 Trumbauersville Road, Quakertown, PA 18951
(215) 536-1562 • Fax (215) 538-9694
www.quakertownfamilydentalcenter.com
E-mail: qfdc@comcast.net

PATIENT INFORMATION ABOUT DENTAL INSURANCE

Our office is aware of the important role dental insurance plays in making dental procedures affordable. We are happy to process your claims at no charge, and in many cases, we participate with the insurance plan and accept their fee schedule. To do this, we need accurate, up-to-date information from you as to what insurance you currently have and the employer/employee information. It is also important to know that we provide the best care possible which may or may not be covered by your dental insurance. Because of this, there are a few facts below to remember:

**Every insurance policy differs according to what your employer and your insurance company have agreed upon.

**Each insurance plan has different deductibles, maximums, procedures covered, and allowances for each procedure.

**No dental insurance is meant to be a "pay-all"; it is meant to be an aid.

**Many routine procedures may not be covered in a particular plan.

With these facts in mind, we will do all we can to determine your coverage and explain what your financial responsibilities will be. However, due to the complexity of the insurance policies, we can only estimate your coverage until the benefits are paid. If the exact benefits are necessary for you to know before dental procedures are undertaken, you should contact your employer or the dental insurance company for the specifics of such procedures, since the insurance company has no obligation to tell us. Even with the proper information, sometimes the insurance company delays payments. In either case, if we are unable to collect payment within 90 days of the treatment date, we will provide you with the claim to send to your insurance company. Since the contract is with you, not us, you will be responsible for the balance due. It is our hope this never happens, and it is rare, but this helps us keep administrative costs down and enables us to pass the savings to you.

Also, for procedures not covered by your insurance, or larger procedures beyond the scope of your insurance, we will provide you with an explanation of payment options.

If you have any questions, we will be happy to help you in any way possible

I have read this form and understand that I am responsible for any fees not covered by my dental insurance coverage and allow insurance payments directly to the provider.

Signature_________________________________ Date____________________

QUAKERTOWN FAMILY DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient #: ______________________ Social Security #: ______________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Brian R. Schoenly, DMD

Telephone: 215-536-1562 Fax: 215-538-9694

E-mail: qfdc@comcast.net

Address: 280 Trumbauersville Rd. Quakertown, PA 18951

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________

Relationship to Patient: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed Consent in the patient's chart

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INFORMED CONSENT FOR LOCAL ANESTHESIA

I understand that my dental treatment may require the use of a local anesthetic for pain control. I understand that a local anesthetic may consist of different medications that are injected into the cheek or gum area. These drugs may include prilocaine, mepivacaine, bupivacaine, articaine, or others. Many people refer to local injections as "Novocaine"; however, this particular drug is seldom used because newer medications are more effective and less likely to cause allergic problems. I understand that local anesthetics may contain a "vasoconstrictor" like epinephrine. I understand that local anesthetics will cause a section of my mouth to become numb, with the numbness lasting from a few minutes to several hours. I know that while my mouth is numb I must be careful not to bite my lips or tongue.
Local anesthetics are among the most common drugs used in a dental office. Complications and side effects are rare, but may include:

- Swelling, bruising, or soreness at the injection site.
- A blood filled swelling, called a hematoma, which can form when a needle, used during an injection, hits a blood vessel.
- Numbness (temporary) outside of the mouth making an eyelid or mouth "droop".
- Temporary rapid heart beat.
- Damage to the nerves resulting in temporary or rarely permanent numbness or tingling of lips, chin, tongue or other areas.
- Rare severe allergic and possible life threatening reactions necessitating emergency care.

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina, or have recently had a heart attack that I will inform my dentist without fail as these conditions have caused complications for persons receiving local anesthesia. I will also inform the dentist of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics.
I understand the recommendation of local anesthetic for my treatment, risks of treatment, any alternatives and risks of these alternatives, including consequences of doing nothing. I have had all of my questions answered, and have not been offered any guarantees.

Patient Signature________________________________Date__________

Witness____