A-Plus Dental Care

Patient Information and Registration

General Information

Patient's Name _____ DOB _____ SSN _____
First MI Last

Name of Spouse or if Child, Name of Parent(s) ☐ Male ☐ Female ☐ Single ☐ Married ☐ Minor

_____ _____
First MI Last First MI Last

Mailing address: _____ City/Town _____

State, Zip _____ Phone (Cell) _____ (H) _____ (W) _____ Email: _____

Employer's name and address: _____

Who is responsible for payment not covered by insurance? _____

Medical History

yes	no		yes	no		yes	no	
☐	☐	Allergies to anesthetics	☐	☐	Stroke	☐	☐	Cancer
☐	☐	Any heart problem	☐	☐	Heart problem	☐	☐	Eye disordrs
☐	☐	High blood pressure	☐	☐	Thyroid problem	☐	☐	Tonsillitis
☐	☐	Neurological problems	☐	☐	Disbetes	☐	☐	Tuberculosis
☐	☐	Radiation treatments	☐	☐	Kidney problems	☐	☐	Ulcer or Colitis
☐	☐	Excessive bleeding from cut	☐	☐	Liver problems	☐	☐	Pregnancy; If yes, Due_____
☐	☐	Anemia or blood problem	☐	☐	Emphysema	☐	☐	Asthma or breathing problem
☐	☐	Joint replacement/implant	☐	☐	Any major operation	☐	☐	Hay fever or allergies in generl
☐	☐	Psychiatric care, depression	☐	☐	Arthritis	☐	☐	Venereal Disease
☐	☐	Heart murmur	☐	☐	Rheumatic fever	☐	☐	Other _____
☐	☐	MVP, MIT	☐	☐	Sinus problems	☐	☐	Allergy to: _Penicillin, _ Motrin, _ Sulfa
☐	☐	Pace make	☐	☐	Aids, HIV, Herpes	☐	☐	To other Med:

Your physician's Name _____ Phone _____

Date of last visit to your doctor _____ Purpose of visit _____

Have you ever, or do you now take illegal drugs _____ If yes, what _____

Are you taking any medication _____ If yes, what _____

Dental History

yes	no		yes	no		yes	no	
☐	☐	Teeth sensitive to cold, hot, etc	☐	☐	Food impaction	☐	☐	Oral habits, i.e. sucking finger
☐	☐	Bleeding gums when brushing	☐	☐	Oral cancer, tumor	☐	☐	Smoking, long _____
☐	☐	Unusual sounds in jaw joint	☐	☐	Bad breath	☐	☐	type, quantity _____
☐	☐	Clenching or grinding teeth	☐	☐	Using dental floss	☐	☐	Allergies to dental anesthesia
☐	☐	Burning of tongue, mucosa	☐	☐	Pain around ear	☐	☐	Using inter dental stimulators
☐	☐	Swelling of lumps in mouth	☐	☐	Periodontal treatment	☐	☐	Using mouth rinsing
☐	☐	Complications from extraction	☐	☐	Orthodontic treatment	☐	☐	Fluoride supplements

Date of last visit of your dentist _____ Where _____

Note: A change in your health status should be reported to the office at your earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered;

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

Person completing the form: Signature _____ Print Name _____

If other than patient, indicate relationship _____ Date _____

Patient's Name _____ DOB _____
First Mi Last

How did know about our clinic? Insurance Dir. ___ Ad. ___ Sign ___ Yellow Pages ___ Patient/Friend _____
Name

Dental Insurance 1

Dental Insurance Company: _____ Insurance Company Phone #: _____
Policy Owner's Name: _____ Policy Owner's DOB: _____
Insurance ID # or SSN: _____ Group #: _____
Relationship to Patient: _____
Insurance Company Address: _____
Tel #: _____
Please present insurance card to front desk.

Dental Insurance 2 (if any)

Dental Insurance Company: _____ Insurance Company Phone #: _____
Policy Owner's Name: _____ Policy Owner's DOB: _____
Insurance ID # or SSN: _____ Group #: _____
Relationship to Patient: _____
Insurance Company Address: _____
Tel #: _____
Please present insurance card to front desk.

I certify that I have provided ALL insurance information. Federal and state law requires that this office from insurance carriers in a specific order.

I certify that I will notify this office of any update of this information.

I hereby authorize a request the performance of dental services for the patient.

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes of dental treatment.

I understand that I am responsible for payment of any denial of coverage due to failure to disclose use of benefits at another office.

I understand the PAYMENT IN FULL is due at time of service by credit card, cash or verified insurance coverage.

I understand that a missed appointment charge will apply for appointment missed with less than one business day notice before appointment.

I have all of my question answered.

Signature of responsible party _____ Date _____

STAFF USE ONLY: Dentist's Medical History Review & Significant Findings

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Doctor Signature _____ **Date** _____

A-Plus Dental Care

434-435 Exton Commons
Exton, PA 19341

Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

1. It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **At each office visit** we need you to show us your insurance card to insure that your current insurance information is on file
2. As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.
3. If a claim is denied, we will research why the rejection occurred and whether resubmit to insurance or bill you the appropriate balance. If the clam is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.
4. If the patient has coverage with a second insurance company, the patient should then submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance.
5. Insurance is a patient's benefit designed to assist the patient in their financial obligation to A-Plus Dental Care. The patient is the one receiving the dental service and therefore is ultimately responsible for all charge on the one receiving the dental service and therefore is ultimately responsible for all charge on the account regardless of any insurance coverage. This applies to everyone in the family who is treated by A-Plus Dental Care.
6. The office will collect the patient's deductible (when services are subject to the deductible) and the estimated balance after insurance at the time services are rendered. After Insurance payment is received the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment.
7. In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless prior arrangements have been approved.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information (X-ray, photo picture, molder, personal information etc), including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services, I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any insurance claims not paid within 60 days of service.

_____ _____

Signature of Patients (parent if minor) or Responsible Party Date

A-Plus Dental Care

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Your Name: _____

Signature: _____

Date: _____

_____

For Office Use Only

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

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (please specify)

_____

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