Person Responsible for Account

The following is for: ❑ parent ❑ spouse ❑ patient (self)

Name: _____
Last First MI

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other _____

Social Security #: _____ Birthdate: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Address: _____

_____

Email # _____

Patient Information

Patient: _____ Date: _____
Last First MI

I prefer to be called: _____ Gender: _____ Family Status: _____

Social Security #: _____ Birthdate: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ❑ Morning ❑ Afternoon ❑ Evening ❑ Anytime ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for todays visit: _____

Previous/present Dentist: _____

Are you currently in pain? ❑ Yes ❑ No

Your current dental health is: GOOD FAIR POOR

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss?

How many times a day do you brush?

Type of bristles? HARD MEDIUM SOFT

Emergency Contact

Name _____

Address _____

_____

Phone _____ Cell _____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No
If yes, please explain: _____

Referral Information

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative
❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Other_____

Name of person or office referring you to our practice: _____

I verbally reviewed the medical/dental information with the patient named herin. Initials: Date:

Doctor's comments:

JEFFREY G. BELL, D.D.S.
GREGORY M. SWENSON, D.D.S.
KIHO MA, D.D.S.
MATTHEW OLMES, D.M.D

susquehanna valley
dental health associates, L.L.P.

"Creating smiles is our business."

FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and up front. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers “usual, customary and reasonable” all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefits amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express and Discover. For those who qualify, we also accept Care Credit.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date to avoid finance charges.
- If the insurance company does not pay in full within 45 days, it will be your responsibility to pay the balance due within 2 weeks.

PATIENTS WITHOUT INSURANCE COVERAGE

- We provide written estimates of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS

- The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at the visit.

RETURNED CHECKS

- A $30 charge applies when a check is returned by the bank

FINANCE CHARGES AND COLLECTION FEES

- A finance charge will be applied to all balances not paid within 30 days of the monthly billing date. Finance charges will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.
- We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE

- An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS

- Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. If you show a history of broken appointments or “no shows” a warning will be given. This warning will be documented. After your warning, if you fail to give the required notice or do not show to your appointment, you may be dismissed from our services.

RECORDS AND REIMBURSEMENTS

- Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION

- I HEREBY DO AUTHORIZE DENTAL TREATMENT AND AGREE TO PAY ALL RELATED
- PROFESSIONAL FEES. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Susquehanna Valley Dental Health Associates. Without any reservations, I agree to abide by the policies outlined herein.

FORM COMPLETED BY:

Printed Name_____Signature_____

IN CASE OF A CHILD:

Relationship to child_____Date_____

Are you the person legally responsible for this child? Yes____No____

- Reviewed by staff member_____Date_____

susquehanna valley
dental health associates, L.L.P.

"Creating smiles is our business."

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowlegement***

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

Patient Name _____

Guardian 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) _____

_____

NAME _____
LAST FIRST M.I.

Have you ever had any of the following?

Y N AIDS/HIV+	Y N EXCESSIVE BLEEDING	Y N TUMORS	Y N EPILEPSY
Y N GLAUCOMA	Y N NERVOUS DISORDERS	Y N PREGNANCY	Y N ULCERS
Y N ANEMIA	Y N HAY FEVER	DUE DATE:	Y N TUBERCULOSIS
Y N ALLERGIES	Y N FAINTING	Y N MENTAL DISORDERS	Y N DIZZINESS
_____	Y N HEAD INJURIES	Y N VENEREAL DISEASE	Y N CANCER
Y N ARTHRITIS	Y N HEART DISEASE	Y N RADIATION TREATMENT	Y N JAUNDICE
Y N ARTIFICIAL JOINTS	Y N HEPATITIS	Y N RHEUMATIC FEVER	Y N BLOOD DISEASE
Y N ASTHMA	TYPE _____	Y N RHEUMATISM	Y N HEART MURMUR
Y N KIDNEY DISEASE	Y N HIGH BLOOD PRESSURE	Y N STOMACH PROBLEMS	Y N DRUG/ALCOHOL ABUSE
Y N DIABETES	Y N SINUS PROBLEMS	Y N SEIZURE/SEIZURE DISORDER	Y N MITRAL VALVE PROLAPSE
Y N RESPIRATORY PROBLEMS	Y N LIVER DISEASE	Y N STROKE	

Are you allergic to any of the following?

Y N ASPIRIN	Y N CODEINE	Y N DENTAL ANESTHETICS	Y N ERYTHROMYCIN
Y N LATEX	Y N PENICILLIN	Y N TETRACYCLINE	Y N OTHER

Please list any other drugs/materials/foods that you are allergic to:

- Name of Physician: _____ Phone: _____
- Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No
  If yes, please explain: _____
- Are you now under the care of a physician? ❑ Yes ❑ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ❑ Yes ❑ No
  If yes, please explain: _____
- Do you use tobacco products? ❑ Yes ❑ No If yes, what products? _____

Please list current medications that you are taking (prescription/over the counter).

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____