Welcome to
Guilford Hills Dental Care

Patient Information

Name:_____

Birthdate:_____ SSN:_____

Address:_____ City:_____ State:____ Zip:____

Cell Phone :_____ Email Address:_____

You will automatically be enrolled in text appointment reminders. If you wish to opt out of text message reminders please initial here _____.

Please circle appropriate marital status:

Minor Single Married Divorced Widowed Separated

Parent or Guardian's Name:_____

Parent or Guardian Phone Number:_____

Whom may we thank for referring you?_____

Person to contact in case of emergency:_____ Phone: _____

Insurance Information

Name of Subscriber:_____

Relationship to Patient:_____

Birthdate of Subscriber:_____

SSN of Subscriber:_____

Name of Employer:_____

Name of Insurance Company:_____

Insurance Address:_____

Subscriber ID :_____ Group #:_____

Please turn over

Medical History

1. Are you currently under medical treatment? Yes__ No__
2. Have you been hospitalized in the last 5 years? Yes__ No__
3. Are you currently taking any medications? Yes__ No__
   If yes, please list medications:_____
   _____
4. Have you ever taken Fen-Phen/Redux? Yes__ No__
5. Have you ever taken Fosamax, Boniva, Actonel? Yes__ No__
6. Do you use tobacco? Yes__ No__
7. Do you use controlled substances? Yes__ No__
8. Are you taking any blood thinners? Yes__ No__

Women Only:

a) Are you pregnant or think you may be? Yes__ No__
b) Are you currently nursing? Yes__ No__
c) Are you taking oral contraceptives? Yes__ No__

Do you have any allergies to the following? If yes, please circle

Amoxicillin/Penicillin Latex Sulfa Drugs Iodine Aspirin
Any metals Sedatives Local Anesthetics Other

Do you have or have you had any of the following?

AIDS/HIV Positive	Yes__No__	Alzheimer's Disease	Yes__No__
Anaphylaxis	Yes__No__	Anemia	Yes__No__
Angina/Chest Pains	Yes__No__	Arthritis/Gout	Yes__No__
Artificial Heart Valve	Yes__No__	Asthma	Yes__No__
Anxiety/Dental Anxiety	Yes__No__	Blood Transfusion	Yes__No__
Breathing Problems	Yes__No__	Bruise Easily	Yes__No__
Cancer	Yes__No__	Chemotherapy	Yes__No__
Cold Sores/Fever blisters	Yes__No__	Diabetes	Yes__No__
Dizziness	Yes__No__	Emphysema	Yes__No__
Epilepsy/Seizures	Yes__No__	Excessive Bleeding	Yes__No__
Frequent Cough	Yes__No__	Frequent Headaches	Yes__No__
GERD/Acid Reflux	Yes__No__	Hay Fever/Allergies	Yes__No__
Heart Attack	Yes__No__	Heart Disease	Yes__No__
Heart Failure	Yes__No__	Heart Murmur	Yes__No__
Hemophilia	Yes__No__	Hypoglycemia	Yes__No__
High Blood Pressure	Yes__No__	High Cholesterol	Yes__No__
Irregular Heartbeat	Yes__No__	Intestinal Disease	Yes__No__
Joint Replacements	Yes__No__	Jaundice	Yes__No__
Kidney Disease	Yes__No__	Leukemia	Yes__No__
Liver Disease	Yes__No__	Low Blood Pressure	Yes__No__
Lung Disease	Yes__No__	Lymes Disease	Yes__No__
Mitral Valve Prolapse	Yes__No__	Osteoporosis	Yes__No__
Pain in Jaw Joint	Yes__No__	Psychiatric Care	Yes__No__
Radiation Treatments	Yes__No__	Rheumatic Fever	Yes__No__
Scarlet Fever	Yes__No__	Shingles	Yes__No__
Sickle Cell Disease	Yes__No__	Sinus Trouble	Yes__No__
Sleep Apnea/Snoring	Yes__No__	Stroke	Yes__No__
Swelling of Limbs	Yes__No__	Thyroid Disease	Yes__No__
Tonsillitis	Yes__No__	Tumors/Growths	Yes__No__
Ulcers	Yes__No__	Venereal Disease	Yes__No__

I certify that the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient/Guardian:_____ Date:_____

Guilford Hills
DENTAL CARE

Financial Policy Notice and Disclaimer

Personal Payments

Patients are responsible for their charges at the time service is provided. We accept major credit/debit cards (Visa, Master Card, Discover, American Express) and check with personal identification and cash.

Patients with Insurance Coverage

Please understand that your insurance coverage is based on a contract between you and your insurance company. The ultimate responsibility for payment always rests with the patient. As a courtesy we will bill your insurance company for its share of the charges you incur if current and correct information is provided. If any claim sent to your insurance company determines that you are "not covered", you are responsible for the total fee. If your insurance company denies, makes partial payments, or takes more than 45 days to remit payment, you are responsible for the unpaid amount.

Financial Options

Monthly financing through Care Credit is available upon approval. Please feel free to request more information about this option.

Minor Patients and Legal Settlements

Guilford Hills Dental Care is not party to any legal settlement resulting from a divorce or child support arrangement. Responsibility for minors rests with the adult accompanying the patient at the time treatment is provided. Payment for services rendered to a minor is the responsibility of the adult accompanying the patient. A parent or legal guardian should be present to sign a treatment consent form for all patients under the age of 18.

Additional Information

There will be an additional charge of $50.00 for each invalid or NSF (Non-Sufficient Funds) check. Any NSF account remaining unpaid after 10 days will be turned over to Collections. Any account remaining unpaid after 30 days may be charged interest at a rate not to exceed that allowed by the state of PA. Any account remaining unpaid for over 60 days for which a payment plan has not been arranged or for which scheduled payments are delinquent may be turned over to a collection agency. If an account has been turned over to a collection agency, the patient is responsible for any additional fees incurred in the collection process. In the event a refund is due, payment will be given within 2 weeks after the amount is verified by Guilford Hills Dental Care. Payment will be rendered in the form of a check.

Cancellation Policy

We reserve the right to reschedule your appointment or decrease the designated appointment time if you arrive 10 minutes late. A $50.00 "Failed Appointment" fee may be charged if our office is not informed with advance notice of 48 hours or more. Chronic failed appointments may result in dismissal from our practice. Any courtesy discounts are subject to cancellation if you do not comply with Guilford Hills Dental Care cancellation policy.

Signature Patient/Guardian: _____ **Date:** _____

Guilford Hills
DENTAL CARE

OUR THREE COMMITMENTS TO YOU

There are three important commitments in our practice. We have put them in writing because, as practice, we promise to always fulfill these commitments to you as a valued patient.

We realize that these commitments may be different from what you may have been accustomed to in other dental practices; however, we believe that they are necessary in building the trust that it takes for us to successfully work together.

COMMITMENT TO TREATMENT

The Guilford Hills Dental Care team will do our best in delivering top-notch dental care and will always stay current with the most successful treatment options available. Our office setting and technology will aim to increase patient comfort and the efficiency of the appointment, while achieving a successful outcome. We will listen and focus on any recommendations around your personal desires, concerns, and goals. Dental disease is nearly 100% preventable; therefore, we ask that you care for your dental health to the best of your ability. Good daily home care is essential for dental health. Starting but not finishing treatment leads to more advanced disease, which unnecessarily adds to your cost and limits the success of treatment. You can choose to have great dental health by following through with your dental plan and home care. We will try our best to help you understand your choices about dental health, allowing you the freedom to make an informed decision.

COMMITMENT TO APPOINTMENT

We will reserve time especially for you in our schedule. We will give you our utmost attention and care and will rarely keep you waiting. An appointment schedule in our office is a bond of trust that our team will be here to serve you and that you will be on time for your appointment. If you are unable to keep your scheduled appointment, we request that you notify us at least two business days in advance.

COMMITMENT TO FINANCIAL CONSIDERATIONS

We have the responsibility to provide our best professional care, skill, and judgement in helping you achieve your dental health goals. As a team we commit to give you up-front information on finances; including cost, payment options, when payment is expected (at or before time of service), and any insurance coverage estimates, (if an insurance predetermination claim was summitted prior to treatment). Be assured we will make every effort to make your dental treatment as affordable as possible by phasing treatment as your circumstances allow. In return, we ask that you keep your end of the financial commitment. REMINDER: The ultimate responsibility for payment always rests with the patient and the patient is responsible for the entire account balance.

Signature: Patient/Guardian_____Date:_____

Guilford Hills
DENTAL CARE

Please read and initial next to each line item for consent or denial for the following:

_____ I hereby acknowledge that Notice of Privacy Practices has been made available to me. I have been given the opportunity to review the Notice of Privacy Practices as well as the Addendum to Notice of Privacy Practices prior to signing this acknowledgment and consent.

_____ I hereby give my permission for Guilford Hills Dental Care to use of my personal health information (dental records including photographs made in the process of examinations, treatment, and retention) for purposes of professional consultation, research, education, payment activities, or publication in professional journals.

_____ I hereby give my consent to have my dental treatment provided by Guilford Hills Dental Care. I understand I will be given the opportunity to have all my questions answered prior to treatment.

_____ I understand that Guilford Hills Dental Care routinely may leave or send messages on an answering machine, voicemail, email and/or text message or with another family member regarding my appointments.

Please list any person(s) that can have to access all aspects of your dental records:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

By signing below I acknowledge that I have read and understand the above information.

_____	_____	_____
Patient's Name	Signature of patient, legal guardian, Or authorized representative	Date