

Welcome



131 Commons Court Chadds Ford, PA 19317
Phone: 610.558.1977 Fax: 610.558.4980
www.EunsonDental.com
Email:Smiles@EunsonDental.com

TODAY'S DATE _____

PATIENT NAME:

Mr. Ms. Rev.
 Mrs. Dr.

LAST FIRST MI PREFERRED NAME

ADDRESS STREET APT # CITY STATE ZIP CODE

PHONE #: HOME WORK CELL TEXT OK? Y N

Where is the best place to call you? Home Work Cell Can we leave a message on your answering machine? Y N

How would you prefer we remind you about your check up appointment (usually every 6 months)? Email Text

SS#: EMAIL ADDRESS:

Gender: M F AGE DOB: Marital Status: Single Married Separated Divorced Widowed

EMPLOYER/SCHOOL OCCUPATION: If student, full time? Y N

Do you have access to a flexible spending account through anyone in your household that you'd like to use? Y N

How did you find out about our office? Tracking our marketing reduces our costs and therefore, your fees. All feedback welcome!!

Chadds Ford Live Yellow Pages Our Website Insurance Website Main Line Today Top Dentist Article

Google Yahoo! Bing Other search engine Online Ad _____
(DO YOU REMEMBER WHICH SITE WERE YOU USING?)

Friend _____ OTHER _____
NAME PLEASE (SO WE MAY SEND THEM A THANK YOU GIFT) (PLEASE LIST)

IN THE EVENT OF AN EMERGENCY, WHO SHOULD BE NOTIFIED? (Someone OTHER than in your household)

NAME: PHONE RELATIONSHIP

SPOUSE INFORMATION OR IF CHILD, PARENT INFORMATION

HIS/HER NAME SS#

EMPLOYER: WORK PHONE BIRTH DATE

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

QUESTIONS APPLY TO SUBSCRIBER (EMPLOYEE)

SUBSCRIBER: PATIENT RELATIONSHIP TO INSURED?

DOB: SS# POLICY ID # GROUP #

EMPLOYER EMPLOYER ADDRESS

INSURANCE COMPANY: INS CO PHONE #:

MEDICAL HISTORY

Physician name: _____ Phone/Town: _____

Approximate date of last physical: _____ Your current health is: Excellent Good Fair Poor

Are you under care of a physician for any condition? Yes No If so, please explain. _____

Please list any medication, herbal supplements or vitamins that you currently take including the dosage and frequency. _____

Please list any other medications taken over the last 2 years not listed above _____

Have you ever been, under treatment for Osteoporosis? Yes No Have you GAINED or LOST 10 or more pounds over the last year? Y N

Have you ever taken any of the following medications: Plavix Coumadin Warfarin Aspirin (daily) Prolia Xgene Pradaxa Fosamax Eliquis Bonivia Actonel Zometa Xarelto

Have you been hospitalized during the past 5 years? Y N If so, for what? _____

Do you smoke or use chewing tobacco? Y N If so, how much per day? _____ Per week? _____ Per year? _____

FEMALE Are you pregnant or is there any possibility you are at this time? Y N If so, due date: _____

PATIENTS

ONLY Do you take oral contraceptives (birth control pills)? Y N Are you nursing? Y N

Have you ever had any of the following medical problems or diseases? Please circle YES or NO to each question.

- Y N Heart Attack Year: _____ Y N Hepatitis Type: _____ Y N Any Artificial Replacements? Knee, Hip, Joints, Pins, Plate What Year: _____
Y N Angina/Chest Pain Y N Liver Problems/Jaundice Y N Rheumatism/Arthritis
Y N Rheumatic Fever Y N Diabetes Type I or Type II Y N Cortisone Medication or Injection
Y N Heart Surgery Y N Tuberculosis (Tb) Y N Lupus
Y N Heart Murmur Y N Asthma Y N Sjogren's Syndrome
Y N Mitral Valve Prolapse Y N Emphysema / COPD Y N Osteoporosis/Osteoporosis treatment
Y N Congenital Heart Lesion/Defect Y N Shortness of Breath Y N Fibromyalgia
Y N Bacterial Endocarditis Y N Hay Fever/Seasonal Allergies Y N Acid Reflux/GERD
Y N Pacemaker / Defibrillator Y N Frequent Headaches Y N Colitis/Irritable bowel syndrome (IBS)
Y N Artificial Heart Valves Y N Glaucoma Y N Gastric Bypass Surgery
Y N High Blood Pressure Y N Parkinson's Disease Y N Sexually Transmitted Disease (STD)
Y N Low Blood Pressure Y N Epilepsy and/or Seizures Y N HIV Positive/AIDS
Y N Hemophilia Y N Multiple Sclerosis Y N Drug/Alcohol Abuse
Y N Excessive Bleeding Y N Thyroid Problems Y N Psychiatric Problems
Y N Sickle Cell Anemia Y N Tumors / Growths
Y N Stroke What Year: _____ Y N Chemotherapy
Y N Kidney Problems Y N Radiation Therapy
Y N Dialysis Y N Cancer Type: _____

Are you allergic (hives or rash) to or have you had an adverse reaction to any of the following?

- Y N Penicillin Y N Motrin/Ibuprophen Y N Jewelry or Metal (Gold, Nickel, Silver, etc.)
Y N Amoxicillin Y N Codeine Y N Aspirin Y N Latex/Plastic
Y N Erythromycin Y N Valium Y N Tylenol/Acetaminophen Y N Epinephrine
Y N Clyndamycin Y N Zanex Y N Aleve/Naproxen Y N Anesthetics/Novocaine

Y N Other _____

I understand the above information is necessary to provide me/my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Guardian Signature: _____ Date: _____

DENTAL HISTORY

Previous Dentist/Location _____ Last exam/cleaning _____

Date of last FULL set of x-rays? _____ Why did you come to the dentist today? _____

Your current dental health is? Good Fair Poor Do you want to save your natural teeth? Yes No

Are you currently in pain/discomfort? Yes No Are any of your teeth loose? Yes No

Do you have any sensitivity to: None Hot Cold Sweets Biting Other: _____

Do you like your smile? Yes No Please CIRCLE the MOST important features in your smile that you would like to CHANGE.

Color Shape Alignment Length Gaps Crowding Gum Display Nothing, I'm happy Other: _____

Please CIRCLE the values that are MOST important to you about your smile.

Esthetics Comfort Longevity Function Long Term Cost Effectiveness

Does food frequently get stuck between your teeth? Yes No If so, where? _____

Do you bite your lips/cheeks frequently? Yes No Do you have difficulty eating or swallowing? Yes No

Do you have dry mouth? Yes No Have you notice a change in your speech or sound of your voice? Yes No

Have you ever responded adversely to medical/dental treatment? Y N If so, how? _____

Did any dentist ever recommend treatment that was never performed? If yes, what type of work was it? _____

_____ Why wasn't work completed? _____

Do you experience pain/discomfort/clicking in your jaw? Yes No Do you grind or clench your teeth? Yes No

Have you had any previous injuries/surgery to your face or jaw? Yes No If so, please list _____

Do your gums ever bleed during brushing? Yes No During flossing? Yes No

How often do you floss? Daily Weekly Monthly Never How often do you brush? _____ Times/Day

Have you ever had gum/periodontal treatment or disease? Yes No If yes, when? _____

What bristles do you use on your toothbrush? Hard Medium Soft Extra Soft Do you use a manual or electric tooth brush? (circle one)

Do you experience stress/anxiety when you visit a dental office? Yes No

Do you normally have regular dental visits (2 times/year)? Yes No Did you ever wear braces? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No If yes: _____

I understand the above information is necessary to provide me/my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Guardian Signature: _____ Date: _____

PATIENT / PARENT / GUARDIAN CONSENT

Consent:

You are requested to read the following paragraphs and to sign your name in the appropriate place if you consent to treatment of yourself by Dr. Anne Eunson or her staff at Eunson Family & Cosmetic Dentistry.

1. I have received the Notice of Privacy Practices and I have had the opportunity to review it.
2. I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
3. I also authorize doctor to perform all recommended operations, procedures, techniques, and/or treatment mutually agreed upon by me and doctor, and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Eunson choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand this consent will remain in force until I revoke it in writing.
5. I hereby state that I have read and understood this consent form, and that I have been given the opportunity to ask questions, I might have, and that all my questions have been answered in a satisfactory manner.
6. ASSIGNMENT OF BENEFITS: I hereby assign dental insurance benefits to which I may be eligible for my dental care to cover the costs of the care and treatment rendered to myself or my dependent for treatment rendered by Dr. Eunson and her staff. I understand that I am responsible for any and all charges not covered by my insurance plan.

Patient/Guardian Signature: _____ Date: _____

Release of Information – We respect your right to privacy. However, often times it useful to have family or a trusted friend help with your treatment and financial options. Please make your choice below:

I authorize the release of my information including diagnosis, records, examination, radiographs, photos treatment plans or anything else that would be helpful in providing my dental care. This information may be released to:

() Spouse _____

() Child(ren) _____

() Other _____

Information is not to be released to anyone.

This **Release of information** will remain in effect until terminated by me in writing.

Patient/Guardian 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify) _____

Office Policy

We have established the following policies to better serve our family of patients. When observed, these policies will allow us to provide you with the following benefits:

- We will be able to stay on schedule and see patients at their appointed times.
- We will be able to offer appointments when you want them, even on short notice.
- We can better accommodate people with busy and unpredictable schedules.

Please check each box to indicate you have read and understand these policies.

Cancelled/Missed Appointments

I understand that I must give notice of at least 2 business days if I must cancel an appointment. We understand that emergencies do arise and that notice of 2 business days may not be possible. Please do your best to inform us as soon as possible.

I understand that if an appointment is missed without prior notice I may be charged \$40 per half hour for a scheduled appointment. If I am more than 15 minutes late for an appointment, it may not be possible to be seen that day and I will be charged \$40 per half hour of your scheduled appointment.

Financial Policy

Payment in full is due at the time of service unless arrangements are made in advance. We accept cash, check, debit card or credit card (VISA, Master Card and Discover Card.)

We will gladly accept assignment of benefits for your insurance if:

- a. We have all necessary insurance information to confirm your benefits prior to your first appointment. It is your responsibility to advise us of any future changes.
- b. Estimated patient co-payments and deductibles are paid at the time of service.
- c. Your insurance company will assign benefits to us. Occasionally, insurance companies will not send their payment directly to our office. In this case, you are responsible for paying the office. We will submit your claims and payment will be sent directly to you, often within 30 days.

Payment Options

Any of the following options must be arranged in advance to your appointment:

Payment of the estimated co-pay at the time of service. While we will do our best to accurately estimate your portion, we do not have control of your insurance company policies. **ULTIMATELY, ANY CHARGES FOR SERVICES PROVIDED ARE YOUR RESPONSIBILITY, REGARDLESS OF DENTAL INSURANCE BENEFITS.**

If a procedure involves multiple visits, ½ of the patient's payment is due at the start of treatment. The remaining balance can then be divided over your remaining appointments. **FINAL PAYMENT DUE PRIOR TO COMPLETION OF TREATMENT.**

If you need to extend payments for your treatment, financing through Care Credit is available. This enables 6-12 months of interest free payment. This option requires payment of your estimated charges when treatment is initiated. Please ask us for more details.

By signing this, you acknowledge that you've read and understand our office policies.

Patient/Guardian Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship: _____