NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle)._____ TITLE: _____

ADDRESS: _____

PREFERRED NAME:_____ SS NO: - - DOB: / /

HOME PHONE: _____ MARITAL: S/M/D/W REF. DOCTOR: _____

WORK PHONE:_____ SEX: M / F REF. PATIENT: _____

CELL PHONE: _____ EMAIL: _____

MEDICAL ALERTS: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS : _____

PLAN NAME:_____ GROUP NO: _____ IND YRLY DEDUCT: _____

INSURANCE CO:_____ FAM YRLY DEDUCT: _____

ADDRESS: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS : _____

PLAN NAME:_____ GROUP NO: _____ IND YRLY DEDUCT: _____

INSURANCE CO:_____ FAM YRLY DEDUCT: _____

ADDRESS: _____

MEDICAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____ RELATION TO PATIENT:_____

ADDRESS: _____

PLAN NAME:_____ GROUP NO:_____

RESPONSIBLE PARTY

NAME AND ADDRESS: _____

SIGNATURE: _____

Patient Name:

Medical History

Check any of the following that you have had or currently have:

- □ Abnormal bleeding
- □ Alcohol abuse
- □ Anemia
- □ Angina Pectoris
- □ Arthritis
- □ Artificial bones
- □ Artificial Heart Valve
- □ Asthma
- □ Blood transfusion
- □ Blood thinners/Aspirin
- □ Bone density problems
- □ Cancer- chemotherapy
- □ Colitis
- □ Congenital heart defect
- □ Cosmetic surgery
- □ Diabetes
- □ Difficulty breathing
- □ Drug abuse
- □ Emphysema
- □ Epilepsy
- □ Fainting spells
- □ Fever blisters
- □ Frequent headaches
- □ Glaucoma
- □ HIV+ AIDS
- □ Heart attack
- □ Heart murmur
- □ Heart surgery
- □ Hemophilia
- □ Hepatitis A B C
- □ High blood pressure
- □ Kidney problems
- □ Liver disease
- □ Low blood pressure
- □ Mitral valve prolapse
- □ Pace maker
- □ Psychiatric problems
- □ Radiation therapy
- □ Rheumatic fever
- □ Seizures
- □ Shingles
- □ Sickle cell disease
- □ Sinus problems
- □ Stroke
- □ Taken Fen-Phen
- □ Thyroid problems
- □ Tuberculosis
- □ Ulcers
- □ Venereal disease
- □ Yellow jaundice

Check any of the following that you are allergic to:

- □ Aspirin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Jewelry
- □ Latex
- □ Metals
- □ Penicillin
- □ Tetracycline
- □ Other _____

_____

Physician Name: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Women Only:

Are you taking Birth Control Pills? ___Yes/___No Are you pregnant? ___Yes/___No If yes, # of weeks ____

Are you nursing? ___ Yes/___No

Medication:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you smoke or use tobacco? ___Yes/ ___No

Are you currently under the care of a physician? ___Yes/ ___No

If yes, for what are you being treated? _____

Have you had any illness, operation or been hospitalized in the past five years? ___Yes/___No

Signature: _____ Date: _____

(Patient's or Guardian's signature required)

Scott A. Creisher, D.D.S, P.C.

Financial/Insurance/Appointment Policy

We realize that every person's financial situation is different. For this reason, we provide a variety of payment options to help patients receive the dental care needed to enjoy a healthy and confident smile.

Payments:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments, and deductibles.

This practice accepts cash, check, VISA, MasterCard, Discover and American Express. We also accept Care Credit which offers special financing options (subject to credit approval). There is a service charge of $25 for returned checks. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling future appointments.

Insurance:

We are happy to file the forms necessary to see that you receive the full benefits of your policy; however, **we cannot guarantee any estimated coverage**. The insurance policy is an agreement between you, your employer and the insurance company. As a courtesy to our patients, we submit all claims directly to your insurance company for services rendered regardless of whether we "participate" or not with your insurance carrier.

You are expected to satisfy any deductible and/or estimated co-payment at the time service is rendered. The guarantor is responsible for any balance not paid by the insurance company within 30 days notice that is a result of the insurance company's:

- Inadequate payment which may include any portion of deductible and/or underestimated co-payments.
- The insurance company not paying a claim within 45 days. If we have not received payment from your insurance company within 45 days of submitting your claim, you are expected to pay the balance in full.
- The patient's failure to cooperate to provide information required by their insurance company to process a claim.
- Having to resubmit a dental claim to an insurance company as a result of inaccurate information supplied by the patient/responsible party.

Regardless of insurance payments, you are responsible for all charges of services rendered. It is also your responsibility to notify the practice of any changes in insurance carriers and/or insurance coverage. If applicable, as a courtesy, we will submit claims to a secondary insurance carrier. We ask our patients to assist us in swift resolution of insurance payments by following up with their employer and insurance carrier when payment is not received within 45 days or if questions arise regarding the explanation of benefits.

If you need assistance or have questions, please contact our office between 8-5 Monday through Thursday at 717-394-2641.

Refunds:

Overpayments will be refunded upon request to the responsible party within 30 days.

Short notice Cancellations and/or Missed appointments:

Our office makes every attempt to remain on schedule throughout the day. We value your time and will do our best to keep you from having to wait. As a courtesy, our office will attempt to contact you for confirmation 1-2 days before your appointment. However, we do ask that patients assume responsibility for their appointment time.

Short notice cancellations and missed appointments represent a cost to us, to you and to other patients who could have been seen in the time reserved specifically for your dental treatment. Any changes to appointments are requested at a minimum of 24 hours prior to the appointment. We reserve the right to charge $25 for missed or short notice canceled appointments. Excessive abuse of missed or short notice canceled appointments may result in discharge from the practice.

I have read and understand the Scott A Creisher, DDS, PC Practice Policies. I agree to assign insurance benefits to the Scott A Creisher, DDS, PC Practice and pay the account in full within 30 days of notice. I agree if it becomes necessary to forward my account to a collection agency or small claims court, in addition to the amount owed, I may be responsible for the fee charged by the collection agency and/or small claims court for the costs of collection.

Signature (Patient, Parent or Guardian):_____

Date:_____

Dr. Scott Creisher & Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____

{Please Print Patient's Name}

_____ _____

{Signature of Patient or Legal Guardian} **{Date}**

I authorize information to be released to:

_____

_____

Confirmation: What is the best way to confirm your dental appointments?

Please Circle- E-mail Home Phone Cell Phone Text Message

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)**

_____

_____