

## 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:**

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

**Check any of the following that you are allergic to:**

- |                                             |                                     |                                       |
|---------------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Jewelry    | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Latex      | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Metals     | _____                                 |
| <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Penicillin |                                       |

**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.**

1059 Columbia Ave Ste. 201

Lancaster, PA 17603

Phone: 717-394-2641

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that this information can be used to:

- \*Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- \* Obtain payment from third-party payers for my health care services.
- \* Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I understand my dental provider has the right to change the **Notice of Privacy Practices** and that I may contact this office at the address listed above to obtain a current copy of the **Notice of Privacy Practices**.

I certify that I have received a copy of this office's **Notice of Privacy Practices**.  
(If we mailed you your new patient forms, we will give you a copy at your first visit.)

\_\_\_\_\_  
(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:    Text Message       E-Mail       Home Phone       Cell Phone

\_\_\_\_\_  
**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 acknowledgement
- \_\_\_ Other (Please Specify) \_\_\_\_\_

# 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 30 days overdue must pay balance in full prior to scheduling future appointments. Delinquent accounts will be turned over to collections.

### 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 (**excluding MEDICARE plans**) to your insurance company for services rendered regardless of whether we "participate" or not with your insurance carrier.

**If we are a participating provider you are expected to satisfy any deductible and/or estimated co-payment at the time service is rendered. If we are out of network, full payment is due at time of service and reimbursement will be sent to the member.** 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.

**You will receive appointment confirmation phone calls / text messages / emails prior to your appointment. If an appointment is not confirmed by the day of the appointment we will notify you that your appointment has been cancelled.**

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 that are less than an hour and \$50 per hour for any appointment that exceeds an hour.** 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, my account will be forwarded to a collection agency, small claims court, Magistrate or Police Department. 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.***

Patient(s) Name \_\_\_\_\_

Signature (Patient, Parent or Guardian): \_\_\_\_\_

Date: \_\_\_\_\_

## INFORMED CONSENT FORM for GENERAL DENTAL PROCEDURES

You have the right to accept or reject any dental treatment recommended by your dentist. Dr. Creisher would like all of his patients to have knowledge of the risks and benefits of dental procedures. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications, alternative treatments or the option of no treatment.

It is very important that you provide Dr. Creisher with an accurate medical history. It is equally important to follow his advice and recommendations regarding medication, pre and post treatment instructions and return for scheduled follow up appointments. If you fail to follow this advice, you may increase the chances of a poor outcome.

I understand that there are certain inherent and potential risks in any treatment plan or procedure, and some of the operative risks include, but are not limited to the following:

- Injury to the nerve underlying the teeth resulting in numbness, tingling, painful or altered sensation in the lip, chin, cheek, teeth and or tongue. This may persist for several weeks, months or on rare occasion, permanently.
- Allergic reaction to anesthetic or medication
- An altered bite in need of adjustment.
- Infection in need of medication, follow up procedure or other treatment.
- The need for replacement of restorations, implants or appliances in the future.
- Damage to the adjacent teeth, restorations or gums that may require treatment.
- Possible deterioration of your condition which may result in tooth loss.
- Possible injury to the jaw and related structures requiring the referral to a specialist. (oral surgery)
- A root tip, fragment or piece of instrument may be left in your body and may have to be removed at a later time if symptoms develop. (oral surgery/ root canal therapy)

Do not sign this form or agree to treatment until you have read, understood, and accepted each statement listed above. Be certain that all of your concerns have been addressed before commencing treatment.

_____ Patient Signature	_____ Date	_____ Witness	_____ Date
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_____ Print Patient Name	_____ Parent/Legal Guardian
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☐ Patient given copy

☐ Patient declined copy