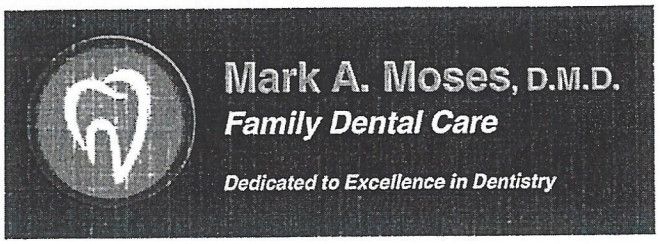

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Phone _____ Soc. Sec. # _____

Name: _____
Last First MI Preferred Name / Title (Mr/Ms/Mrs/etc.)

Gender: ❑ M ❑ F Age_____ Birthdate _____ ❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Divorced

Address _____
Street City ST Zip

Whom may we thank for referring you to our practice? _____

In case of emergency, who should be notified? _____ Phone _____

Preferred Appointment Times: ❑ Mon ❑ Tue ❑ Wed ❑ Thu ❑ Fri ❑ Morning ❑ Afternoon ❑ Evening ❑ Anytime

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account: _____
Last First Mid. Ini.

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
(spouse, parent, guardian, etc.)

Address (if different from above) _____
Street City ST Zip

Best Time to Call: _____ eMail Address: _____

Employer Name: _____ Phone: _____

Employer Address: _____
Street City ST Zip

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Group # _____ Contract # _____ Subscriber # / ID # _____

Insurance Address: _____
Street City ST Zip

SECONDARY INSURANCE INFORMATION

Is patient covered by additional insurance? ❑ Yes ❑ No Relationship to Patient _____

Subscriber Name _____ Birthdate _____ Soc. Sec. # _____

Address (if different from above) _____
Street City ST Zip

Insurance Company: _____

Group # _____ Contract # _____ Subscriber # / ID # _____

Insurance Address: _____
Street City ST Zip

HEALTH INFORMATION

DENTAL HISTORY

Date of Last Dental Visit: _____ Reason for this Visit: _____

Former Dentist: _____ Address: _____

Check (✔) if you have had any problems with any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding Teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Have you ever had any of the Following? Please check those that Apply:

- ❑ AIDS
- ❑ Alllergies
  - ❑ Codeine Allergy
  - ❑ Penicillin Allergy
  - _____
  - _____
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valves-
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Headaches
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Pregnancy
  Due Date: _____
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Problems
- ❑ Skin Rash
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Swelling of Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ OTHER: _____
  _____

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

Have you been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No
If yes, please explain: _____

Are you under the care of a physician? ❑ Yes ❑ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ❑ Yes ❑ No
If yes, please explain: _____

Medications:

List medications you are currently taking: _____

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: _____

Signature of patient, parent or guardian

Mark A. Moses, D.M.D.
Family Dental Care
Dedicated to Excellence in Dentistry
3127 Wilmington Road, New Castle, PA 16105
Phone 724-656-1510 • Fax 724-656-4908

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due.

I agree that a waiver of any breach of any time or condition set forth herein shall not constitute a waiver of enforcement any such term or condition. I further agree that in the event I shall be in default of the terms or conditions herein and legal action is commenced to enforce such term(s) or condition(s). I hereby agree that I shall be responsible for any and all costs and reasonable Attorney's fees to institute collection efforts or any other legal proceeding that may prove I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Authorization

I authorize my insurance company to pay to the dentist or dental group, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment or benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

❑ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date _____

Relationship to Patient: _____ Response Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.