# ACQUAINTANCE FORM

The information you give us is strictly confidential and will not be released to anyone without your permission.

## PATIENT INFORMATION

Patient's Name_____Email address_____

Address_____

Home #_____ Cell# _____ Social Security #_____Date of Birth_____

Employer Name_____Work Telephone_____

Marital Status_____If Married, Spouse's Name_____

How Did you Happen To Chose Our Office? (Please circle) Magazine Google Location Personal Referral:_____

## EMERGENCY INFORMATION

In Case of Emergency Contact_____ Relationship _____

Address_____Telephone_____

## RESPONSIBLE PARTY INFORMATION

Person Responsible For Payment_____Relationshp_____

Address_____

Telephone_____Social Security #_____Date of Birth_____

## INSURANCE INFORMATION

Dental Insurance Company Name_____

Address_____

Group #_____Subscriber Name_____Social Security #_____

IF DUAL COVERAGE--THE SECONDARY INSURANCE COMPANY:

Insurance Company Name_____Employer_____

Address_____Group #/Policy #_____

Relationship_____Subscriber Name_____Social Security #_____

**MEDICAL HISTORY** *Please check or circle any of the following which you **have** or **have had** and explain where necessary. List prescribed medications you are taking now for each.*

☐1. AIDs_____

☐2. Anemias or Blood Discrasias_____

☐3. Arthritis, Rheumatoid or Osteo_____

☐4. Asthma_____

☐5. Autoimmune Conditions_____

☐6. Birth Control Pills, Hormone Replacement Therapy or Fertility Problems_____

☐7. Blood Clots or Stroke: Y/N Treatment: _____

☐8. Bone Problems, Osteoporosis_____Treatment w/Bisphosphonates(Please circle or write): Fosamax Actonel Boniva Zometa oral or injection Other:_____

☐9. Cancer or Tumors: Y/N Current Treatment:_____ Previous Treatment:_____

☐10. Depression or Nervous Disorders_____

☐11. Diabetes: Type I or Type II ☐A. Oral Medication_____ ☐B. Insulin Injections_____

☐12. Digestive Conditions, Acid Reflux, GERD_____

☐13. Epilepsy or Seizures: Y/N Last episode:_____

☐14.Hayfever or Allergies other than medications_____

☐15.Heart Problems_____

☐A. Cardiac Bypass Surgery_____ ☐B. Cardiac Pacemaker_____

☐C. Congenital Heart Defect_____ ☐D. Prosthetic Heart Valve_____

☐E. Heart Attack_____ ☐F. Heart Murmur, Mitral Valve Prolapsed_____

☐16. Hepatitis A,B, C or Liver Disease_____

☐17.High Blood Pressure_____ ☐18. Low Blood Pressure_____

☐19. Joint Replacement_____ Premedication: Y/N Antibiotic:_____

☐20. Kidney Disease _____

☐21. Lung Disease, COPD_____

☐22. Muscle Diseases_____

☐23. Social Diseases_____

☐24. Thyroid Diseases_____

☐25. Tuberculosis or Symptoms of Tuberculosis_____

☐26. Other diseases or conditions not listed_____

**Please list any vitamins, supplements or herbal/homeopathic remedies that you are currently taking:**

_____ _____

_____ _____

_____ _____

**Are you allergic to any of the following:**

☐ Antibiotics ☐1.Penicillin ☐2.Erythromycin ☐3.Tetracycline ☐4.Sulfa ☐5.Keflex ☐6.Clindamycin ☐7.Other_____

☐Local Anesthetics like Lidocaine or Septocaine or Carbocaine_____ ☐Epinephrine sensitivity_____

☐Aspirin ☐Codeine ☐Ibuprofen, Motrin, Advil ☐Aleve ☐ Narcotics_____

☐Latex ☐Metals of any kind_____

☐Other allergies to materials or medications_____

**Have you ever been advised to take medication (antibiotics or other medications) before a dental appointment? Y/N** (circle) **If so, please explain**_____

Have you ever had a skin rash or a reaction to metal jewelry? Y/N (circle) To What?_____

Do you wear contact lens? Y/N (circle) Do you bleed excessively upon injury? Y/N (circle)

Do you drink alcohol? Y/N (circle) _____daily _____weekly _____monthly _____ socially_____

Do you smoke now or **have you ever** smoked? Y/N (if yes number of years) cigarettes/day_____

cigars_____ pipes_____ chewing tobacco or snuff_____

Women: Is there a possibility that you may be pregnant or trying to get pregnant? Y/N (circle)

If yes, how many months pregnant? _____

Are you in a job that regularly exposes you to radiation or chemicals? Y/N (circle) _____

Have you ever had counseling for addictions to alcohol and/or prescription medications? Y/N (circle)

Do you have reason to believe you are at risk for contacting infectious or sexually transmitted diseases?

Y/N (circle) If yes, please explain_____

Have you been hospitalized in the past two years Y/N (circle) If yes, please explain_____

_____

Physicians name and phone #:_____Date of last physical_____

Are you experiencing emotional or physical stress or pressure in your work or at home? Y/N (circle)

Please explain_____

Is there anything other in your medical history that we have missed? _____

**DENTAL HISTORY**

Name and contact # of previous Dentist_____

Date of last visit_____ Were x-rays taken? Y/N (circle)_____

Have you had regular cleanings and exams? Y/N (circle)

Do you have a fear or phobia or the dentist that prevents you from visiting the dentist on a regular basis? Y/N (circle)
Would you be interested in help to deal with this fear, such as the use of Nitrous Oxide? Y/N (circle)

Have you lost teeth? Y/N (circle) Why?_____

Have you had complications with extractions?_____

Have you worn braces?_____ When?_____ How Long?_____ Do you still wear retainers?_____

Have you had treatment for periodontal disease (gum disease) or where you told you had periodontal disease?_____ Please explain and give dates_____

How often do you brush your teeth? ____x/day AM___PM___ Do you floss?_____x/day

Do you use other hygiene aids?_____

Do your gums bleed when you brush?____ or floss?_____

Do you have an unpleasant taste in your mouth?_____

Are there any areas of your mouth where foods collects or wedges between your teeth?_____

Have you noticed a dry mouth? Y/N Excessive water drinking/sipping? Y/N Frequent Use of Lozenges? Y/N

Do you have clicking or popping sounds when you open or close your mouth?_____ Pain?_____

Do you clench or grind your teeth either during the day or at night?_____

Do you experience headaches?_____ Frequency? _____When do they come?_____

Are any of your teeth sensitive?_____ Sweets? _____Cold?_____ Hot?_____ Pressure?_____

**Are you interested in mercury safe removal of amalgam (mercury) fillings?**_____

## TREATMENT AUTHORIZATION

I consent to whatever dental procedures and anesthetics are necessary for treatment. I also understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of Patient or Guardian_____Date_____

Signature of Dentist_____Date_____

# Hershey Dental Associates, LLC

**273 Hershey Rd**
**Hummelstown, PA 17036**
**(717) 220-1792**
**www.hersheydental.com**

## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

**By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation**

I, _____, authorize Hershey Dental Assoc, LLC to release
(please print)

information to the following individual(s):

_____

Name Relationship

_____

Name Relationship

This consent will remain in effect until withdrawn by you in writing, or on the following date, condition, or event:

_____

I understand that I may revoke this authorization at any time by sending a written notice of my revocation (except to the extent that the information has already been released).

_____

Signature of Patient Date

_____

Signature of Witness Date

HERSHEY DENTAL ASSOCIATES, L.L.C.

# Photo and Testimonial Release Form

I, _____, hereby grant permission to Hershey Dental Associates, LLC to use my photograph and any testimonial I give regarding the dental care I receive from any such office, in any marketing, contests, advertising or teaching materials used to market or advertise his/her dental practices, including use on Hershey Dental Associates, LLC's website. Hershey Dental Associates, LLC will not utilize your likeness or image without your expressed and written permission.

I acknowledge Hershey Dental Associates, LLC may choose not to use my photograph and testimonial at this time, but may do so at Hershey Dental's own discretion at a later date.

I also understand that once my image is posted on Hershey Dental Associates, LLC's website, the image can be downloaded by any computer user, which beyond the control of Hershey Dental Associates, LLC, and I will hold the practice and any of its affiliates harmless from any such use or download.

**I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.**

Signature: _____ Date:_____

(Parent/Guardian signature if under age of 18)

**To revoke this consent in writing, please contact:**
Hershey Dental Associates, LLC
273 Hershey Road
Hummelstown, PA 17037

HERSHEY DENTAL ASSOCIATES, L.L.C.

# Information about Dental Insurance

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurances; we realize how confusing it can be. To begin, we would like to highlight a misconception- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid by you or your employer. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient. Ultimately financial responsibility falls on the patient.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask the front desk staff, insurance coordinator, and/or office manager for clarification on services, billing, and insurance.

Sincerely,

Hershey Dental Associates, LLC

Patient Name: _____

Patient Signature: _____ Date: _____

Staff Responsible: _____ Date: _____

# HERSHEY DENTAL ASSOCIATES, L.L.C.

We are committed to providing you with quality dental care. This is a breakdown of our policy which must be read and signed prior to treatment in addition to Health History and an Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA) before being seen by the doctor.

Please understand that the payment of your bill is considered a part of your treatment and is due at the time of service unless covered by a participating insurance company. We accept MasterCard, Visa, Discover, American Express, Care Credit, Check, or Cash.

**Regarding Insurance:** **All charges incurred at each dental visit are your responsibility regardless of your insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you, our patient. Your insurance policy is a contract between you, your employer, and the insurance company. It is ultimately your responsibility to be aware of dental benefits, make sure your policy is active on the date of service, verify if our practice is in or out of network with your insurance policy and to be aware of any deductible and maximum allowance. As a courtesy, our staff will assist in filling out and submitting your insurance claim. Patients with dental insurance will be responsible to pay the estimated insurance copayment and deductible at the beginning of treatment and authorize the assignment of the insurance benefits to us. After insurance payments are received, any overpaid amounts will be refunded to you. You will receive a statement if there is an amount due.

**If you do not have insurance or we are not participating with your insurance, payment is expected at the time of service**. Our staff will file your insurance claim, and will mark the payment as payable to you directly. Your insurance claim can only be submitted if we are supplied with the proper insurance information from you. If you have questions regarding your dental benefits, or a problem with reimbursement, please contact your employer or insurance company.

**Patient's Initials:** _____

**Usual and Customary Fees:** Our fees reflect what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of what is an appropriate charge.

**Missed appointments:** Notice of 24 hours is required for cancellation. We understand that situations arise making it impossible for you to keep your appointment. Please keep in mind that a missed appointment can cause a lapse in important treatment, inefficient use of time for the staff and physicians, and a missed opportunity for another patient who may have needed an appointment. Monday appointments must be confirmed or rescheduled by the prior Thursday. Missed appointments may be subject to a $50 cancellation fee.

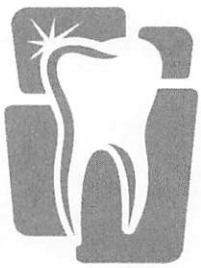
**Returned Checks:** Patients will be charged $50 for each returned check, and are responsible for the amount owed.

**Past Due Balance:** A service fee of 35% may be added if there has been no attempt to make payment or set up a payment plan. All past due amounts must be paid before an appointment can be scheduled

I have read and understand the financial policy as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date



HERSHEY DENTAL ASSOCIATES, L.L.C.

## Acknowledgement of Receipt of Notice of Privacy Practices

**You may Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practice.

Print Name: _____

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

_____ Communications Barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)_____

_____