MEDIA
FAMILY DENTISTRY
RESTORATIVE • IMPLANT • COSMETIC

214 State Road, Media, PA 19063
Phone (610)566-5322
Fax (610)-566-5325

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Student ☐ Other_____

Social Security #: _____ Birth Date_____ Email:_____

Driver's License State _____ Driver's License Number:_____

Phone (Home): _____ (Work): _____ Ext_____ Mobile: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for the person <u>responsible</u> for payment.

Employer _____ Work Phone_____ Occupation: _____

Address: _____
Street City State Zip Code

The following is for the patient.

Employer _____ Work Phone_____ Occupation: _____

Address: _____
Street City State Zip Code

Medical Health Information

Physician_____ Office Phone_____

Person to contact in case of emergency_____ Phone_____

	YES	NO
Are you taking any prescription/non-prescription medications, vitamins or herbs?	☐	☐
If **yes** what medication(s) are you taking?_____		
_____		
Have you ever been told to **pre-medicate** prior to any dental appointment?	☐	☐
Do you use Alcohol?	☐	☐
Do you use Tobacco?	☐	☐
Do you have a persistent cough or throat clearing **not** associated with a known illness (lasting more than 3 weeks)?	☐	☐

Have you ever had any of the following? Please check those that apply:

☐ AIDS or HIV
☐ **Allergies**:
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Other _____

☐ Anemia
☐ Angina
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chest Pains
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fen-phen/Redux
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Nervous Disorders
☐ Cardiac Pacemaker
☐ Pregnancy-*current only*
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ STD(s)
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
OTHER:
☐ _____
☐ _____
☐ _____

Patient Dental History

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are you sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel **pain** in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you ever experienced any of the following problems in your jaw?	☐	☐
Clicking?	☐	☐
Pain (Ear, Side of Face)?	☐	☐
Pain in TMJ (Temporomandibular Joint)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	YES	NO
Do you have frequent **headaches**?	☐	☐
Do you **clench** or **grind** your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any **difficult** extractions?	☐	☐
Have you had any Orthodontic work?	☐	☐
Have you ever had **prolonged** bleeding following extractions?	☐	☐

Date of Last Dental Visit: _____

What is you chief complaint and reasoning for appointment? _____
_____

- 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 now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

_____
_____
_____

Comments:

_____
_____
_____
_____

Signature of Dentist **Date**

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

Responsible Party Information

The following is for the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Mobile:_____ Email:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary

Name of Subscriber: _____ Is subscriber a patient? ☐Yes ☐No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name_____ Address:_____

Phone Number _____ ID # _____

Secondary ***If Applicable**

Name of Subscriber: _____ Is subscriber a patient? ☐Yes ☐No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other_____

Insurance Plan Name:_____ Address: _____

Phone Number:_____Group #:_____ _____

Referral Information

How did **you** hear about our office ☺? ☐Another patient/friend, if so what is their name? :_____

☐ Google ☐ Yelp ☐ School ☐ Work ☐ Insurance Company ☐ Driving By ☐ Other _____

The REFERRAL of your friends and family is the GREATEST compliment you can give to us at Media Family Dentistry!!!

Consent of Services - Office Policy – Office Philosophy

OFFICE PHILOSOPHY

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves on helping you in any way and continuing to provide the quality of care to which you have become accustomed.

ELECTIVE SERVICES

Some services are typically not covered by dental insurance companies. These include, but are not limited to: cosmetic dentistry, chips or cracks in teeth or older restorations, implants, occlusion or bite redesign, posterior composites, and other services.

Although these are important dental services that can greatly enhance the quality of life for patients and may be needed in most cases, some dental insurance companies do not feel they should have to pay for these services. That is why these services are rarely included in contracts with your employers.

OFFICE POLICY

We have done our best to obtain ESTIMATED dental benefits based on our office fees. You are expected to pay your estimated portion **at the time services** are rendered unless other arrangements have been made in advance.

Please note that our office is a participating provider with several insurance companies, however, we are unable to determine in advance the **actual** final payment from your dental insurance company until ALL claims close and are finalized. Upon receipt of final payment from the insurance company, in the case of overpayment, your account will be credited. In the event of an underpayment, we will generate a billing statement for the unpaid balance.

I understand that the fee estimate listed for dental care can only be extended for a period of **six months** from the date of the patient examination.

I grant my permission to you or your assignee to contact me at home or at my work to discuss matters related to this form.

Finally, it is important to remember, services are provided to you and not to your insurance company. You are financially responsible.

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

X **/ /**

PATIENT/PARENT, or GUARDIAN SIGNATURE **Date**

Hitesh Sachdeva, DMD
214 State Road
Media PA, 19063
Phone: (610) 566-5322

Written Financial Policy

Thank you for choosing Media Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card.
- NO INTEREST [1]PaymentPlans[2] from CareCredit allow you to pay over time with NO INTEREST (1) with no annual fees or pre-payment penalties

Please Note:

Media Family Dentistry requires payment of patient portion at the time of treatment. Before lab work can be sent out, 50% of the case fee must be paid. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patient's cost over $1200.00, payment plans can be discussed and alternative payment arrangements may be provided. For large comprehensive treatment plans of $500 or more, a 20% deposit *may* be required to secure your initial treatment *appointment*.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. [(3)] Insurance plans do vary greatly; we will estimate the patient's co-pay to the best of our ability. Any portion not covered by your insurance plan is the account holder's (patient's) responsibility.

MEDIA FAMILY DENTISTRY CHARGES $40 FOR PATIENTS WHO MISS OR CANCEL WITHOUT OUR OFFICE STAFF *RECEIVING* 48-BUSINESS HOURS NOTICE, and $40 for NSF or cancelled checks.

If you have any questions, please do not hesitate to ask. We are here to help you meet your dental needs and to work together for your dental health.

Patient, Parent or Guardian Signature_____

Patient Name (PleasePrint)_____**Date**_____

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2] Subject to credit approval. [3] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's
Please Print Name
Notice of Privacy Practices.

_____
Please 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)

_____

_____