DENTAL GROUP, P.C.
Strasburg
DENTAL CARE CUSTOMIZED FOR YOU

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, proud of our dedication to our patients and the relationships we have formed. Our goal is to help you feel and look your very best through excellent dental care, so that you will feel comfortable coming here and recommending us to others.

We are also proud of our highly trained staff. Each one has been handpicked for his or her ability to serve you. We realize that you are an individual with preferences of your own, so we try to personalize our approach to each patient. Alternative methods and fees will be discussed openly, and you may choose what is best for you. On your first visit with us, we will listen to your dental concerns and answer all of your questions thoroughly. You can expect a thorough examination with only necessary imaging and a discussion of the most appropriate treatment to meet your oral health needs.

Please be prepared for your appointment by completing the new patient registration forms. Please bring a list of all current medications, including over the counter, vitamins and herbal preparations. If you have dental insurance, be sure to provide all requested information. As a courtesy, we will file claims on your behalf. Payment is expected at the time of the first visit. We accept most major credit cards, cash and personal checks. If you would like to finance your dental expenses we work with CareCredit. We will be glad to provide you with information about CareCredit and how to apply.

The Doctors and Staff of Strasburg Dental Group

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PATIENT HEALTH HISTORY FORM

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

DATE:____________ PATIENT:____
Last Name First Name Initial Preferred Name

DATE OF BIRTH _________ CELL PHONE ______________HOME PHONE ______________EMAIL ______________________________

HOME ADDRESS ____

[] SINGLE [] MARRIED [] WIDOWED [] SEPARATED [] DIVORCE EMPLOYER ______________________WORK PHONE _____________

MEDICAL DOCTOR/SPECIALIST ____

HAVE YOU HAD AN ORTHOPEDIC TOTAL JOINT (HIP, KNEE, SHOULDER, ELBOW, FINGER) REPLACEMENT? [] Yes [] No
IF YES, DATE__________________

HAVE YOU BEEN TOLD YOU SHOULD BE TAKING AN ANTIBIOTIC (PREMEDICATION) PRIOR TO DENTAL VISITS? [] Yes [] No
IF YES WHAT ANTIBIOTIC DO YOU TAKE ___________________________________

ARE YOU TAKING A BLOOD THINNER (COUMADIN) ? [] Yes [] No **EVER HAD A BLOOD TRANSFUSION?** [] Yes [] No

ARE YOU PRESENTLY TAKING A MEDICATION FOR SOFT BONE (OSTEOPOROSIS) (FOSAMAX)? [] Yes [] No

(WOMEN) ARE YOU PREGNANT? [] Yes [] No **NURSING?** [] Yes [] No **TAKING BIRTH CONTROL PILLS**? [] Yes [] No

DENTAL ISSUES: [] CLENCHING [] GRINDING [] CLICKING/POPPING JAW JOINT [] OTHER ________________________________

CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

[] ACID REFLUX/GERD
[] ADHD/ADD
[] AIDS/HIV POSITIVE
[] ALCOHOL DEPENDENCY
[] ALZHEIMERS/DEMENTIA
[] ANEMIA
[] ARTHRITIS,RHEUMATISM
[] ASTHMA/COPD
[] BACK/NECK PROBLEMS
[] BLOOD DISEASE
[] CANCER-Type ____________
[] CHEMICAL DEPENDENCY
[] CHEMOTHERAPY
[] CIRCULATORY PROBLEMS

[] CORTISONE TREATMENTS
[] CROHNS DISEASE
[] DIABETES-TYPE I, II
[] EATING DISORDER
[] EXCESSIVE BLEEDING
[] FAINTING
[] GASTRO INTESTINAL
[] HEART ARTIFICIAL VALVES
[] HEART DISEASE -Describe
____
[] HEART MVP
[] HEART MURMUR
[] HEART PACEMAKER
[] HEMOPHILIA

[] HEPATITIS –Type____________
[] HIGH BLOOD PRESSURE
[] KIDNEY DISEASE
[] LIVER DISEASE
[] MIGRAINES/HEADACHES
[] MULTIPLE SCLEROSIS
[] NERVOUS/ANXIETY ISSUES
[] ORGAN TRANSPLANT________
[] PARKINSON'S
[] PERSISTENT COUGH
[] PSYCHIATRIC CARE/BIPOLAR
[] RADIATION TREATMENT
[] RESPIRATORY DISEASE
[] RHEUMATIC FEVER

[] SEIZURE DISORDER
[] SEXUALLY TRANSMITTED DISEASE
[] STROKE
[] THYROID PROBLEMS
[] TOBACCO /MARIJUANA/VAPE
[] TUBERCULOSIS
[] ULCER
[] VERTIGO
[] VISION ISSUES/GLAUCOMA
[] OTHER _________________
____
____
____

MEDICATIONS/SUPPLEMENTS: List all you are currently taking *OR* give list to receptionist to copy) __________________
____
____

ALLERGIES: [] ASPIRIN [] BARBITURATES(Sleeping Pills) [] CODEINE [] LATEX [] LOCAL ANESTHETIC [] PENICILLIN

[] SULPHA [] NONE [] OTHER: ____

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION OR ANY OTHER CONDITIONS OR ISSUES: [] Yes [] No

IF YES, DESCRIBE____
____

HIPAA Office Information – By signing this form, I acknowledge that I am aware that this office's Notice of Privacy Practice is available to me at the front desk and my signature constitutes acknowledgement of such policy. I am free to ask any questions. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

EMERGENCY CONTACT: **NAME** ____________________**PHONE**__________________**RELATIONSHIP**_____________

Signature of Patient/Legal Guardian____**Date** _______________________

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PATIENT INFORMATION FORM

ACCOUNT INFORMATION

DATE:__________ PATIENT:____
Last Name First Name Initial Preferred Name

PLEASE COMPLETE IF PERSON RESPONSIBLE FOR ACCOUNT IS OTHER THEN THE PATIENT:

NAME ______________________ RELATIONSHIP TO PATIENT ______________ PHONE______________

ADDRESS ____

PRIMARY INSURANCE INFORMATION

DENTAL INSURANCE CO ______________________ GROUP #______________

INSURANCE ADDRESS ____

SUBSCRIBER'S SOCIAL SECURITY NUMBER:______________

SUBSCRIBER'S NAME ______________________ BIRTHDATE______________

EMPLOYER NAME ______________________ RELATIONSHIP TO PATIENT______________

SECONDARY INSURANCE INFORMATION

DENTAL INSURANCE CO ______________________ GROUP #______________

INSURANCE ADDRESS ____

SUBSCRIBER'S SOCIAL SECURITY NUMBER:______________

SUBSCRIBER'S NAME ______________________ BIRTHDATE______________

EMPLOYER NAME ______________________ RELATIONSHIP TO PATIENT______________

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I understand 24 hours notice is expected if I need to cancel an appointment, otherwise there may be a fee of $50-$250 assessed. I also understand that any accounts over 30 days are subject to late and/or finance charges (18%APR). I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. It is my responsibility to notify your office of future changes. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I hereby authorize payment (directly to the dental office) of the group insurance benefits otherwise payable to me. I understand that any estimates given by Strasburg Dental Group for insurance coverage are estimates and that I am responsible to know the limitations of my insurance policy. We file dental insurance as a courtesy for established patients. I must pay the estimated non-covered portion at the time of treatment, and whatever the insurance company does not pay is my responsibility to make up in a timely manner. We accept Visa, Mastercard, Discover, American Express and Care Credit cards for your convenience. We do accept personal checks, however, returned checks are subject to a $35.00 NSF Fee.

I have read, understand and agree to the information above.

Signature of patient or responsible party ______________________ Date ______________

Relationship to patient if other than patient ____________________________________

PATIENT DENTAL HISTORY

1. Purpose of Visit: ____
2. How long since your last dental visit: ________________________________
3. What was done at that time:_______________________________________
4. When was the last time your teeth were cleaned _________________________
5. Have you had dental x-rays taken in the last year ________________________
6. Do you clench or grind your teeth? YES NO
7. Does your jaw click or pop? YES NO
8. Are any of your teeth sensitive to ( ) Hot? ( )Cold? ( ) Sweets? ( ) Pressure?
9. Do your gums bleed or hurt? YES NO
10. Do you experience Dry Mouth? YES NO
11. How often do you brush your teeth? ______________When ______________
12. Do you use dental floss? YES NO
13. Are any of your teeth loose, shifted or chipped? YES NO
14. Are you unhappy with the appearance of your teeth? YES NO
15. Are you happy with the color of your teeth and any fillings or crowns you have?
    YES NO
16. Have you had any unpleasant dental experiences or is there anything about dentistry
    that you strongly dislike? ____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ( )Another patient, friend

( ) Another patient, relative ( ) Dental Office ( ) Yellow Pages ( ) Website

( ) Newspaper ( ) School ( ) Work ( ) Other ___________________________

Name of person or office referring you to our practice: _________________________