Garden Spot Dental Care, PC

101 West Main Street • New Holland, PA 17557 (717)354-3200

Welcome to Garden Spot Dental Care

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

I prefer to be contacted by

☐ Cell Phone ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

Insurance Subscriber and/or Parent/Guardian Information

This page ONLY needs to be filled out if the insurance subscriber is OTHER than the patient AND/OR you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Dental Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

_____

_____

Approximate date of most recent dental exam and/or dental x-rays

_____

_____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/Have braces or orthodontic treatment
☐ Experiences dry mouth
☐ Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Whitened or bleached your teeth
☐ Experienced popping and/or clicking of your jaw joint
☐ Difficulty chewing
☐ Clenching or grinding of teeth
☐ Currently or previously wore a bite appliance
☐ Wears removable partial/denture
☐ Gums bleed when brushing or flossing
☐ Diagnosed and/or treated for gum disease
☐ Bone loss around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ Snores or wakes up frequently during the night

If any of the checked boxes need further explanation, please describe:

Patient Financial Policy

Please read through and check each box indicating that you understand our financial policy as an insured or un-insured patient.

Insurance Patients:

As a courtesy, any patients with dental insurance will have claims submitted on your behalf to your insurance company with any necessary information. Insurance is not a guarantee of payment. You, as the patient, are responsible for any balance that is not paid to us within 60 days of submission.

☐ * **By checking this box,:**

I authorize payment to go directly to Garden Spot Dental Care.

I authorize Garden Spot Dental Care to submit any dental treatment to my insurance company.

I authorize the release of any necessary records, this includes clinical notes, x-rays, and photos taken in order to receive payment from my dental insurance company.

I authorize Garden Spot Dental Care to act as my agent in helping me obtain payment from my insurance company.

I authorize my electronic signature on all insurance submissions.

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

Insured and Self-Pay Patients:

☐ * **By checking this box:**

I understand that payment is due at time of service.

I understand that an unpaid balance will be subject to a 2.75% monthly finance charge. 21% APR after 30 days past due with a minimum monthly finance charge of $2.00.

Cancellation Policy

☐ * **Dr West as well as our hygienists time is very valuable. A minimum of 24 hours notification to cancel your appointment is required. Failure to give proper notification will result in a cancellation charge. This is NOT covered under insurance and you will be responsible for that charge**

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Response Date: ____/____/_____