Pearly Whites, LLC
Family & Cosmetic Dental Center
(215) 295-4851
www.drpearlywhites.com
info@drpearlywhites.com

Welcome to Our Practice!

Patient Information

Patient's Last Name_____ First Name_____

Middle_____ Title_____ Preferred Name_____ Marital Status_____

Social Security_____-_____-_____ Birth Date_____/_____/_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____

Work Phone_____-_____-_____ E-Mail_____

Occupation_____ Employer_____

Employment Address_____

Emergency Contact_____ Phone_____-_____-_____

Relationship to Patient_____

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

For Full-Time College Students: School_____

Phone at School_____-_____-_____

Email at School_____

Responsible Party Information **(if different from above)**

Responsible Party Last Name_____ First Name_____

Middle_____ Title_____ Preferred Name_____ Marital Status_____

Social Security_____-_____-_____ Birth Date_____/_____/_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____

Work Phone_____-_____-_____ E-Mail_____

Occupation_____ Employer_____

Employment Address_____

Insurance Information

Subscriber- Last Name_____ First Name_____

Middle_____ Is insured a patient? Yes No Insured's Relationship to Patient _____

Insured's Social Security_____-_____-_____ Insured Birth Date_____

Insurance Company_____

Insurance ID #:_____ Insurance Group #_____

Insurance Company Phone_____-_____-_____ Insured's Employer_____

Employment Address_____ Work Phone_____-_____-_____

If you have dual coverage, please complete the following secondary insurance information

Subscriber-Last Name_____ First Name_____

Middle_____ Is insured a patient? Yes No Insured's Relationship to Patient _____

Insured's Social Security_____-_____-_____ Insured Birth Date_____

Insurance Company_____

Insurance Company Phone_____-_____-_____ Insured's Employer_____

Employment Address_____ Work Phone_____-_____-_____

Medical Information

Are you currently under medical treatment? Yes No

Have you been a patient in the hospital during the past two years? Yes No

Date of most recent medical exam:_____

Physician's Name_____ Physician's Phone_____

Please list any medications or drugs you are currently taking, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins, etc._____

_____

Please list any medications or anesthetics to which you are allergic_____

Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart Failure	Yes	No	Sinus Trouble	Yes	No	Whiplash Injury	Yes	No
Heart Disease or Attack	Yes	No	Hay Fever	Yes	No	Severe Blow to Head	Yes	No
Angina Pectoris	Yes	No	Respiratory Problems	Yes	No	Severe Blow to Jaw	Yes	No
Congenital Heart Failure	Yes	No	Allergies	Yes	No	Chronic Back Pain	Yes	No
Heart Murmur	Yes	No	Latex Allergy	Yes	No	Chronic Shoulder Pain	Yes	No
High Blood Pressure	Yes	No	Codeine Allergy	Yes	No	Chronic Neck Pain	Yes	No
Arteriosclerosis	Yes	No	Penicillin Allergy	Yes	No	Stiff Neck Muscles	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatitis A (infectious)	Yes	No	Tension Headaches	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis B (serum)	Yes	No	Migraine Headaches	Yes	No
Heart Pacemaker	Yes	No	Hepatitis C	Yes	No	Headaches in Back of Head	Yes	No
Heart Surgery	Yes	No	Venereal Disease	Yes	No	Headaches in Temple Area	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No	Chronic Facial Pain	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No	Pain in Jaw Joint	Yes	No
Anemia	Yes	No	Hemophilia	Yes	No	Clicking, Popping Jaw	Yes	No
Arthritis	Yes	No	Sickle Cell Disease	Yes	No	Locking Jaw	Yes	No
Rheumatism	Yes	No	HIV	Yes	No	Tired Jaw After Sleep	Yes	No
Cortisone Medication	Yes	No	Easy Bruising	Yes	No	Tired Jaw After Meal	Yes	No
Artificial Joints (hip, etc)	Yes	No	Yellow Jaundice	Yes	No	Foods You Avoid	Yes	No
Liver Disease	Yes	No	Epilepsy or Seizures	Yes	No	Aching Jaw Opening Wide	Yes	No
Kidney Trouble	Yes	No	Nervousness	Yes	No	Difficulty Opening Wide	Yes	No
Diabetes	Yes	No	Anorexia/Bulimia	Yes	No	Trouble Sleeping	Yes	No
Ulcers	Yes	No	Wisdom Tooth Extraction	Yes	No	Cracking in Jaw Joint	Yes	No
Thyroid Problems	Yes	No	Bleeding Gums	Yes	No	Teeth Clenching	Yes	No
Glaucoma	Yes	No	Family History of Jaw Problems	Yes	No	Teeth Grinding at Night	Yes	No
Cancer	Yes	No	Ear Pain	Yes	No	Sore Teeth After Sleep	Yes	No
Radiation Therapy	Yes	No	Itchiness in Ear	Yes	No	Blurred Eyesight	Yes	No
Chemotherapy	Yes	No	Stuffiness in Ear	Yes	No	Snoring	Yes	No
Emphysema	Yes	No	Ringing/Buzzing in Ear	Yes	No	Chronic Stuffed Nose	Yes	No
Chronic Cough	Yes	No	Loss of Hearing	Yes	No	Recurring Nausea	Yes	No
Tuberculosis	Yes	No	Pain In/Around/ Behind Ear	Yes	No	Hives	Yes	No
Tumors	Yes	No	Fainting or Dizzy Spells	Yes	No			
Asthma	Yes	No	Involvement in Accident	Yes	No			

Do you have or have had any disease, condition or problem not listed on the previous page? Yes No

If yes, please identify_____

Did you take the diet drug Fen-Phen that is no longer on the market? (You made need to pre-medicate) Yes No

Do you have a history of alcohol or chemical dependency or of an emotional disorder or of any developmental disability that may have an impact on your needs or the care we provide? Yes No

Do you smoke and/or chew tobacco? Yes No

Do you wish to speak with the doctor privately about anything? Yes No

For Women: Are you pregnant? Yes No Due Date_____

Are you nursing? Yes No Are you taking any birth control pills?* Yes No

* If you are using non-mechanical contraceptives. Antibiotics may interfere with their effectiveness. Consult your physician; you may wish to use mechanical forms of birth control for one full cycle after completion of antibiotic treatment

If you experience headaches, please complete the following questions

If you take medication for pain relief, what do you take? _____

How often do you take it? _____

When are your symptoms the worst? _____

Does anything make you feel better? _____

If you have been involved in a serious accident, will you provide details? _____

_____

When you experience headaches, do you also experience the following?

_____Fatigue _____Nausea _____Light Sensitivity _____Noise Sensitivity _____Blurred Vision _____Dizziness

Please indicate the location and type of pain Key: L=Left R= Right B= Both Sides

				Severity			***Frequency***			***Duration***				
			Location	**Mild**	**Moderate**	**Severe**	**Occasional**	**Frequent**	**Constant**	**Seconds**	**Minutes**	**Hours**	**Days**	**Weeks**
_	R	B	Front of head											
_	R	B	Entire head											
_	R	B	Back of head											
_	R	B	In Temples											

Financial Responsibility

Consent:

1. I understand that the above information is necessary for the doctors to provide me with comprehensive dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge
2. I authorize the doctors of Pearly Whites, LLC to take radiographs and photographs, make study models, or employ other diagnostic aids deemed appropriate by them for the purpose of making a thorough diagnosis of my dental needs.
3. I authorize the doctors of Pearly Whites, LLC to perform all recommended treatment with which I have agreed and to use the appropriate medication and therapy indicated for such a treatment. I understand that using anesthetic agents embodies a certain risk.
4. I authorize the release of examination findings, diagnosis, treatment program, etc., to my referring or treating dental specialists and/or physicians.
5. I understand that all responsibility for payment for dental services provided in this office for myself and/or for my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
6. If I have dental insurance, I realize that my insurance coverage represents a contract between my insurance company and me and that said coverage depends upon the plan that I have chosen or that the insured's place of employment has purchased on my behalf. I am aware that some procedures I may require may not be a benefit of my particular plan. I also understand that Pearly Whites, LLC submits my claims to my insurance carrier purely as a courtesy to me. Should insurance payment be denied or should reimbursement be less than the estimate amount, I am responsible for the treatment fee in full.
7. If I have dental insurance, I realize that I am responsible for maintaining contact with my insurance carrier though the phone number on my insurance card in order to monitor reimbursement paid throughout the contact year relative to the maximum coverage allowed. Should the maximum benefit coverage be exceeded in a given contract year, I am responsible for the balance that remains.
8. I understand that it is my responsibility to advise of any information contained in this form.
9. If I am 18 years of age or older and if my parents/guardians are my guarantors, I give permission for Pearly Whites, LLC to submit dental claims on my behalf to the insurance company to white my parents/guardians subscribe. I give permission for Pearly Whites, LLC to place a phone call to my parents'/guardians' home regarding those claims, account balances, and/or account credits and/or to mail statements or other information to my parents'/guardians/ home address regarding those claims, account balances, and/or account credits.

Patient Signature_____ Date_____

OR

Signature of Parent or Responsible Party_____

Relationship to Patient_____ Date_____

Cancellation Policy

We need to ensure that our office stays on schedule so each that patient is seen on time. If you are unable to keep an appointment, we require that you provide us with two business days notice for rescheduling. We understand that situations may arise and this notice will allow us to offer an appointment to another patient in need of treatment.

If an appointment is cancelled or missed without notifying our office within the requested time, we reserve the right to charge a fee of $50.00 for revenues lost. All fees must be paid prior to rescheduling another appointment.

Thank you for your understanding, Pearly Whites only wishes to insure each patient with the amount of time and care required.

Patient Signature_____ Date_____

SECTION A: Consent of Patient

Name_____

Address_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____

E-Mail_____

Social Security Number_____-_____-_____

SECTION B: To The Patient- *Please read the following statements carefully*

Purpose of Consent: By the signing of this form, you hereby consent our use and disclosure of your information regarding your health to carry out treatment, have access to payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. Pearly Whites, LLC provides a description of our treatment, payment activities and healthcare options, of the uses of disclosure we make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and understand prior to you signing this consent. Pearly Whites, LLC reserves the right to change its Privacy Practices as described in our Notice of Privacy Practices. If any changes were to be made, we will reissue a revised Notice of Privacy Practices which will contain these changes. These changes may apply to any of your protected health information we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice of Privacy Practices at any time by contacting our office at
(215)295-4851,or by mailing us at 799 West Trenton Avenue, Morrisville, PA 19067.

RIGHT TO REVOKE: You will have the right to revoke This Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action Pearly Whites, LLC took prior to receiving your revocation and that we reserve the right to decline further treatment to you if and after you revoke this consent.

SIGNATURE:
I, _____, have had the full opportunity to read and consider the contents of this consent form and your use and disclosure of my protected health information and to carry out treatment, payment activities and health care operations.
Signature_____ Date_____

If this consent is hereby a personal representative/guardian on behalf of the patient, please complete the following:

Representative/Guardian Name: _____Relationship_____
Signature of Personal Representative/Guardian_____