NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle): _____ TITLE: _____

ADDRESS: _____

PREFERRED NAME: _____ SS NO: - - DOB: / /

HOME PHONE: _____ MARITAL: S/M/D/W REF. DOCTOR: _____

WORK PHONE: _____ SEX: M / F REF. PATIENT: _____

CELL PHONE: _____ EMAIL: _____

MEDICAL ALERTS: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS : _____

PLAN NAME: _____ GROUP NO: _____ IND YRLY DEDUCT: _____

INSURANCE CO: _____ FAM YRLY DEDUCT: _____

ADDRESS: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS : _____

PLAN NAME: _____ GROUP NO: _____ IND YRLY DEDUCT: _____

INSURANCE CO: _____ FAM YRLY DEDUCT: _____

ADDRESS: _____

MEDICAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

RESPONSIBLE PARTY

NAME AND ADDRESS: _____

SIGNATURE: _____

Patient Name: Patient Test

Medical History

Check any of the following that you have had or currently have:

- □ Abnormal bleeding
- □ Alcohol abuse
- □ Anemia
- □ Angina Pectoris
- □ Arthritis
- □ Artificial bones
- □ Artificial Heart Valve
- □ Asthma
- □ Blood transfusion
- □ Blood thinners/Aspirin
- □ Bone density problems
- □ Cancer- chemotherapy
- □ Colitis
- □ Congenital heart defect
- □ Cosmetic surgery
- □ Diabetes
- □ Difficulty breathing
- □ Drug abuse
- □ Emphysema
- □ Epilepsy
- □ Fainting spells
- □ Fever blisters
- □ Frequent headaches
- □ Glaucoma
- □ HIV+ AIDS
- □ Heart attack
- □ Heart murmur
- □ Heart surgery
- □ Hemophilia
- □ Hepatitis A B C
- □ High blood pressure
- □ Kidney problems
- □ Liver disease
- □ Low blood pressure
- □ Mitral valve prolapse
- □ Pace maker
- □ Psychiatric problems
- □ Radiation therapy
- □ Rheumatic fever
- □ Seizures
- □ Shingles
- □ Sickle cell disease
- □ Sinus problems
- □ Stroke
- □ Taken Fen-Phen
- □ Thyroid problems
- □ Tuberculosis
- □ Ulcers
- □ Venereal disease
- □ Yellow jaundice

Check any of the following that you are allergic to:

- □ Aspirin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Jewelry
- □ Latex
- □ Metals
- □ Penicillin
- □ Tetracycline
- □ Other _____
  _____

Physician Name: _____ Phone: _____
Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Women Only:
Are you taking Birth Control Pills? ___Yes/___No Are you pregnant? ___Yes/___No If yes, # of weeks ____
Are you nursing? ___ Yes/___No

Medication:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you smoke or use tobacco? ___Yes/ ___No
Are you currently under the care of a physician? ___Yes/ ___No
If yes, for what are you being treated? _____
Have you had any illness, operation or been hospitalized in the past five years? ___Yes/___No

Signature: _____ Date: _____
(Patient's or Guardian's signature required)

Dr. Scott Creisher & Associates
1059 Columbia Ave Suite 201
Lancaster, PA 17603
Phone: 717-394-2641

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).
I understand that this information can be used to:

- *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- * Obtain payment from third-party payers for my health care services.
- * Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I understand my dental provider has the right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address listed above to obtain a current copy of the ***Notice of Privacy Practices***.

I certify that I have received a copy of this office's ***Notice of Privacy Practices***.
(If we mailed you your new patient forms, we will give you a copy at your first visit.)

_____
(Please Print Patient(s) Name)

_____ _____
(Signature of Patient or Legal Guardian) (Date)

I authorize information to be released to:

_____

_____

Confirmation: What is the best way to confirm your dental appointments?
Please Circle: Text Message E-Mail Home Phone Cell Phone

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

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify) _____

Scott A. Creisher, D.D.S, P.C.

Financial/Insurance/Appointment Policy

We realize that every person's financial situation is different. For this reason, we provide a variety of payment options to help patients receive the dental care needed to enjoy a healthy and confident smile.

Payments:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments, and deductibles.

This practice accepts cash, check, VISA, MasterCard, Discover and American Express. We also accept Care Credit which offers special financing options (subject to credit approval). There is a service charge of $25 for returned checks. Patients with an outstanding balance of 30 days overdue must pay balance in full prior to scheduling future appointments. Delinquent accounts will be turned over to collections.

Insurance:

We are happy to file the forms necessary to see that you receive the full benefits of your policy; however, **we cannot guarantee any estimated coverage**. The insurance policy is an agreement between you, your employer and the insurance company. As a courtesy to our patients, we submit all claims directly to your insurance company for services rendered regardless of whether we "participate" or not with your insurance carrier.

If we are a participating provider you are expected to satisfy any deductible and/or estimated co-payment at the time service is rendered . If we are out of network, full payment is due at time of service and reimbursement will be sent to the member. The guarantor is responsible for any balance not paid by the insurance company within 30 days notice that is a result of the insurance company's:

- Inadequate payment which may include any portion of deductible and/or underestimated co-payments.
- The insurance company not paying a claim within 45 days. If we have not received payment from your insurance company within 45 days of submitting your claim, you are expected to pay the balance in full.
- The patient's failure to cooperate to provide information required by their insurance company to process a claim.
- Having to resubmit a dental claim to an insurance company as a result of inaccurate information supplied by the patient/responsible party.

Regardless of insurance payments, you are responsible for all charges of services rendered. It is also your responsibility to notify the practice of any changes in insurance carriers and/or insurance coverage. If applicable, as a courtesy, we will submit claims to a secondary insurance carrier. We ask our patients to assist us in swift resolution of insurance payments by following up with their employer and insurance carrier when payment is not received within 45 days or if questions arise regarding the explanation of benefits.

If you need assistance or have questions, please contact our office between 8-5 Monday through Thursday at 717-394-2641.

Refunds:

Overpayments will be refunded upon request to the responsible party within 30 days.

Short notice Cancellations and/or Missed appointments:

Our office makes every attempt to remain on schedule throughout the day. We value your time and will do our best to keep you from having to wait. As a **courtesy**, our office will attempt to contact you for confirmation 1-2 days before your appointment. However, we do ask that patients assume responsibility for their appointment time.

Short notice cancellations and missed appointments represent a cost to us, to you and to other patients who could have been seen in the time reserved specifically for your dental treatment. Any changes to appointments are requested at a minimum of 24 hours prior to the appointment. We reserve the right to **charge $25 per hour** for missed or short notice canceled appointments. Excessive abuse of missed or short notice canceled appointments may result in discharge from the practice.

I have read and understand the Scott A Creisher, DDS, PC Practice Policies. I agree to assign insurance benefits to the Scott A Creisher, DDS, PC Practice and pay the account in full within 30 days of notice. I agree if it becomes necessary, my account will be forwarded to a collection agency, small claims court, Magistrate or Police Department. In addition to the amount owed, I may be responsible for the fee charged by the collection agency and/or small claims court for the costs of collection.

Patient(s) Name _____

Signature (Patient, Parent or Guardian):_____

Date:_____

INFORMED CONSENT FORM for GENERAL DENTAL PROCEDURES

You have the right to accept or reject any dental treatment recommended by your dentist. Dr. Creisher would like all of his patients to have knowledge of the risks and benefits of dental procedures. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications, alternative treatments or the option of no treatment.

It is very important that you provide Dr. Creisher with an accurate medical history. It is equally important to follow his advice and recommendations regarding medication, pre and post treatment instructions and return for scheduled follow up appointments. If you fail to follow this advice, you may increase the chances of a poor outcome.

I understand that there are certain inherent and potential risks in any treatment plan or procedure, and some of the operative risks include, but are not limited to the following:

- Injury to the nerve underlying the teeth resulting in numbness, tingling, painful or altered sensation in the lip, chin, cheek, teeth and or tongue. This may persist for several weeks, months or on rare occasion, permanently.
- Allergic reaction to anesthetic or medication
- An altered bite in need of adjustment.
- Infection in need of medication, follow up procedure or other treatment.
- The need for replacement of restorations, implants or appliances in the future.
- Damage to the adjacent teeth, restorations or gums that may require treatment.
- Possible deterioration of your condition which may result in tooth loss.
- Possible injury to the jaw and related structures requiring the referral to a specialist. (oral surgery)
- A root tip, fragment or piece of instrument may be left in your body and may have to be removed at a later time if symptoms develop. (oral surgery/ root canal therapy)

Do not sign this form or agree to treatment until you have read, understood, and accepted each statement listed above. Be certain that all of your concerns have been addressed before commencing treatment.

_____ _____

Patient Signature Date Witness Date

_____ _____

Print Patient Name Parent/Legal Guardian

REVIEW DATE/PT INITIAL: _____ : _____ : _____

_____ : _____ : _____ : _____ : _____

☐ Patient given copy ☐ Patient declined copy