CHART #: _____

Patient Name: _____ **Date of Birth:** _____
Social Security #: _____ **Gender: M F**
Phone #'s: (H): _____ **(C):** _____ **(W):** _____

Email Address: _____

Mailing Address: _____
_____

Insurance Company: _____
ID #: _____
Group # _____
Group Name (Employer): _____
Subscriber Name: _____
Subscriber D.O.B.: _____
Subscriber Address (If Different Than Patient): _____
_____

Guarantor Information:

◯ SAME AS PT.

Name: _____ **D.O.B:** _____
S.S.N.: _____ **Gender: M F**
PHONE #'S: (H): _____ **(C):** _____
(W): _____
Employer: _____
Address: _____
_____
Relationship to Patient: _____

How did you hear about Glenside Dental? _____
Date of Last Dental Check-up/Cleaning: _____
Reason for Today's Visit: _____

I confirm that all above information is correct. I agree to inform Glenside Dental of any changes to the above information in a timely manner.

_____ _____
Patient/Guarantor Signature **Date**

Glenside Dental reserves the right to amend its policies at any time.

CHART #: _____

Health History

Please check all that apply.

- ☐ AIDS/HIV+
- ☐ ASPIRIN ALLERGY
- ☐ CODEINE ALLERGY
- ☐ ERYTHRO ALLERGY
- ☐ HAY FEVER ALLERGY
- ☐ LATEX ALLERGY
- ☐ PENICILLIN ALLERGY
- ☐ SULFA ALLERGY
- ☐ TYLENOL ALLERGY
- ☐ OTHER ALLERGY: _____
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HEAD INJURIES
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ JAUNDICE
- ☐ JOINT REPLACEMENT
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL/NERVOUS DISORDERS
- ☐ PACEMAKER
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY ISSUES
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SINUS ISSUES
- ☐ STROKE
- ☐ STOMACH PROBLEMS
- ☐ TUBERCULOSIS
- ☐ CANCER
- ☐ TUMORS
- ☐ ULCERS

Are there any other allergies, illnesses, or serious health issues the doctor should know of?

_____

Are you required to pre-medicate? Y N

Are you currently pregnant? Y N
If YES, when is your due date? _____

Do you take blood thinners? Y N

Are you on an ASPIRIN regimen? Y N

Have you ever had any complications after dental treatment? Y N
If YES, explain: _____

In the past two years have you been hospitalized or visited the E.R.? Y N
If YES, explain: _____

Are you under the care of a physician? Y N
If YES, explain: _____
Doctor Name: _____ Phone #: _____

I confirm that all above information is true and accurate to the best of my knowledge. Should I have any changes to my health conditions I will notify Glenside Dental as soon as possible to avoid any future complications.

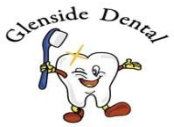
_____ _____

Patient/Guarantor Signature **Date**

Glenside Dental reserves the right to amend its policies at any time.

[Type text]

CHART #: _____



FINANCIAL POLICY

- ***INSURANCE*:** Glenside Dental participates with MOST PPO insurance plans. At this time we do not accept ANY DMO plans. If at the time of your appointment our staff is unable to verify eligibility and benefits, the patient will be considered self-pay. Patients will be refunded if/when claim is paid. We will gladly submit your insurance claim for you. Patients/Guarantors are responsible for all deductibles, co-pays, co-insurance portions, and any non-covered services. Please understand that your insurance plan is a contract between you, the employer group, and the insurance company. We are not part of that contract and our financial relationship is with YOU. All charges are the patient's/guarantor's responsibility. Payment Plans are available when certain criteria are met. Please see office manager for further details.
- ***PAYMENT OPTIONS:*** Glenside Dental accepts ALL major credit and debit cards, cash, and money orders. Glenside Dental does not accept personal checks.
- ***PATIENT PORTIONS:*** All portions quoted are ESTIMATES ONLY and are due AT THE TIME OF SERVICE. We do strive to estimate your portion as accurately as possible, but your actual portion may differ from what you were quoted. If there is an additional amount owed once the insurance has processed your claim, Glenside Dental will send a bill to the patient's/guarantor's listed address.
- ***PAST-DUE BALANCES:*** If a patient's account balance is 60 days past due a pre-collection letter will be sent out. If the balance remains unpaid at 90 days past due, the balance will be forwarded to our collection agency where collection fees and daily interest will be accrued. Should your account be sent to collections the patient's relationship, as well as any immediate family members, with Glenside Dental will be terminated until the balance and all collection fees are paid in full. Collection payments can be made directly to the collection agency or her at Glenside Dental. If a patient files bankruptcy, the patient and any immediate family members will be dismissed as patients from Glenside Dental.
- ***BROKEN APPOINTMENTS:*** Glenside Dental requires 24 hours notice to cancel or change an appointment. If proper notice is not provided the patient's account will be charged a $50.00 broken appointment fee. If more than 3 appointments are broken future appointment privileges may be revoked and the patient may be dismissed.
- ***H.I.P.P.A:*** Glenside Dental takes our patient's privacy very seriously. A patient's private health information will not be shared with anyone unless it is pertinent or necessary to their care or treatment OR the patient has given written permission for us to do so.

I understand and agree to the above policies. Any and all questions have been answered by the staff and/or doctor. I also understand that the above polices may change at any time without notice.

I have reviewed and agree to Glenside Dental's privacy policies. I understand I may request a copy of the H.I.P.P.A. law at anytime from Glenside Dental.

_____ _____

Patient/Guarantor Signature Date

Glenside Dental reserves the right to amend its policies at any time.

[Type text]