

WELCOME

**Thank you for selecting our dental healthcare team.
We look forward to working with you in maintaining your dental health.**

Date ____/____/____

Name _____
Last First M.I.

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Pager Phone (____) _____

E mail address _____

Date of Birth ____/____/____ Social Security # ____-____-____

Single Married Divorced Widowed

Name of Your Employer _____

Person to Contact in Case of an Emergency _____

Their Home Phone (____) _____ Work Phone (____) _____

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

Insurance Information ** (If you are the subscriber of account, you only need to fill out the first two questions)

Name of Insurance _____

Group Number _____

Name of Subscriber _____

Name of Employer _____

Is this form for Spouse Child

Subscriber's Social Security # ____-____-____

Subscriber's Date of Birth ____/____/____

Do you have secondary insurance? Yes No

Name of Insurance _____

Group Number _____

Subscriber's Social Security # ____-____-____

Name of Employer _____

YOUR MEDICAL HISTORY

1. Are you in good health? Yes No If no, please explain _____
2. Are you under a physician's care now? Yes No If yes, please give reason for treatment _____
3. Name of Your Physician _____ Address _____
4. Has there been any recent change in your general health? Yes No If yes, please explain _____
5. Date of Your Last Physical Examination ____/____/____
6. Are you taking any medications at this time? Yes No If yes, please list _____
7. Please check any illnesses you have had or presently have.
 - Allergies Glaucoma Diabetes Rheumatic Fever
 - Heart Valve(leaking or defective) Psychiatric Tuberculosis High Blood Pressure
 - Multiple Sclerosis Low Blood Pressure Hepatitis Lung Conditions
 - HIV Positive AIDS Pace Maker Joint Replacement
 - Asthma Epilepsy Heart Trouble Kidney/Liver Problem
8. Do you have any condition not listed above that you think we should know about? Yes No If yes, please explain _____
9. Do you have any trouble with prolonged bleeding? _____
10. Have you ever had any unusual reaction to an anesthetic or drug (like penicillin)? Yes No If yes, please explain _____
11. Do any family members have diabetes? Yes No
12. Do you smoke? Yes No If yes, how much _____
13. Do you use smokeless tobacco? Yes No If yes, how much and how long _____
14. What is the name of your water company? _____

YOUR DENTAL HISTORY

1. Your last dental visit? _____
2. Name of previous dentist? _____ Address _____
3. Does your child take fluoride at home? Yes No
4. What is your dental preference?
 - local anesthetic (Novocaine) no anesthetic relative analgesia (Nitrous Oxide)
 - oral premedication I.V. Sedation
5. Have you ever had any unfavorable reactions from previous medical or dental care? Yes No If yes, please explain _____
6. Have you ever had periodontal disease? Yes No
7. Are you pleased with the appearance of your teeth? Yes No If no, why? _____
8. Are you in pain now? Yes No If yes, where? _____
9. Do your gums bleed? Yes No If yes, please explain _____
10. Do your teeth feel loose? Yes No If yes, please explain _____
11. Do you grind or clench your teeth during the day or night? Yes No
12. Do you have sore or sensitive teeth? Yes No If so, is it to: sweets hot cold
13. Do you have pain elsewhere in your face or jaws? Yes No If yes, where? _____
14. Does food collect between your teeth? Yes No
15. Do you think you have bad breath? Yes No

I, the undersigned, do affirm that the above information is correct and do give consent to agreed upon dental service, and use of appropriate methods thereto.

Signed _____ Date ____/____/____
Patient or Guardian

Date: ____/____/____

Patient: _____

Parent or Guardian: _____

Address: _____ Phone: (____) _____

I hereby agree to pay Dr. Warren D. Silvers, D.M.D. for professional services rendered. I understand that I am responsible for the entire amount due, payable at the time of services unless prior financial arrangements have been made.

If there is dental insurance, then services will be billed to the carrier as a courtesy and all monies received will be credited to my account. I am responsible for any charges, processing delays or other circumstances. All unpaid charges will be reflected on a monthly statement. We reserve the right to attach finance charges on any balance over 30 days old.

I understand that when appropriate, credit bureau reports may be obtained. I am responsible for copayment and/or deductibles at the time of service.

Signature of person responsible for account: _____

Date: ____/____/____

INSURANCE SIGNATURE ON FILE

(Sign only if you have insurance)

The benefits payable under the below named insurance policy have been assigned to:
Warren D. Silvers, D.M.D., 4392 Sturbridge Drive, Harrisburg, PA 17110.

AUTHORIZATION TO PAY BENEFITS TO DENTIST:

I hereby authorize payment directly to Warren D. Silvers, D.M.D. for all dental benefits entitled to me for dental treatment. I understand that I am financially responsible for all charges not covered by this assignment for any reason.

Insurance Company's Name _____

AUTHORIZATON TO RELEASE INFORMATION:

I hereby authorize Dr. Silvers to release any information acquired in the course of my examination or treatment to the above named insurance company, or to any dentist to whom I am referred.

Signed _____ Date ____/____/____