Date_____ # INITIAL PATIENT REGISTRATION

Patient: _____
Last Name First Name Nickname/Preferred Name

Birth Date _____ Social Security Number: _____ Age_____ Gender: □M □F

Address: _____ Email: _____ @ _____

City _____ State _____ Zip Code _____

Home Phone: [_____]_____ Cell Phone: [___]_____ Work Phone: [_____]_____

Employed by_____ Occupation: _____

*Referred by:*_____ *May we send them a 'Thank You' note: []Yes []No*

* MINORS, name of parents: _____

Emergency Contact: [Name/Relationship]_____ *Their Phone* → **[ ]** - _____

INITIAL MEDICAL HISTORY

Are you under the care of a physician? □Yes □ No

For What Conditions? _____

Name of doctor that supervises/oversees your medical care: _____

LIST all medications you are taking and for what condition you are taking them. Include over-the-counter medications and herbal supplements.

Medication Name	Reason Used/ Prescribed	Doctor who prescribed	***Office Use Only***

Allergies to Medications? _____

*** *Is there anything else we should know about your medical history?* _____

Do you have or have you ever had in the past:

□Y □N Latex Allergy
□Y □N Rheumatic Fever
□Y □N Hemophilia /Clotting Disorders
□Y □N High Blood Pressure
□Y □N Anticoagulants /Blood Thinner
□Y □N Diabetes_____
□Y □N Thyroid Disease
□Y □N Hepatitis □ A □ B □C
□Y □N Ulcers / Gastric Reflux
□Y □N Autism: [] verbal [] non-verbal

□Y □N Heart Murmur
□Y □N Artificial Heart Valves
□Y □N Heart Disease
□Y □N PACEMAKER
□Y □N Daily aspirin
□Y □N Respiratory Disease
□Y □N Epilepsy / Seizures
□Y □N AIDS/HIV
□Y □N Chemical Dependency

□Y □N Mitral Valve Prolapse
□Y □N Artificial Joint Replacement
□Y □N Stroke
□Y □N EVER taken 'Premedication'
□Y □N Cancer_____
□Y □N Radiation Treatment
□Y □N Osteoporosis / Osteopenia
□Y □N Sinus Problems

Women:

□Y □N Do you Suspect you are pregnant? Due Date: _____ Are you nursing? □Yes □ No

Physician Name:_____ Phone Number: ___[_____]_____ Last Visit: _____ **Name of Specialist:** _____ Phone Number: ___[_____]_____ Last Visit: _____ Specialty: _____ **Name of Specialist:** _____ Phone Number: ___[_____]_____ Last Visit: _____ Specialty: _____	**~ Updates and Reviews ~**

DENTAL HISTORY

Why do you seek dental care at this time? _____
Date of last exam:_____ Date of last Cleaning: _____ How often do you brush your teeth? _____

Date of last dental treatment other than check up: _____ Do you use floss? □Yes □ No How often?_____

Reason for that visit: _____

Do you have any of the following?

- □ Teeth sensitive to hot or cold, sweets or pressure
- □ Bleeding gums
- □ Food impaction between teeth
- □ Swelling or lumps in mouth
- □ Frequent blisters on lips or mouth
- □ Bad breath or unpleasant taste
- □ Have you ever been told you had / have gum disease?
- □ Loose teeth
- □ Pain around ear
- □ Clenching or grinding of teeth
- □ Jaw clicking or popping
- □ TMJ / jaw problems
- □ Any other pain or problem in the mouth
- □ Have you ever had orthodontic treatment [braces]?
- □ Have you had any serious trouble associated with any previous dental treatment?

Please make any other comments you wish to share with us: _____

_____

DENTAL INSURANCE INFORMATION

If child, responsible party: _____ Relationship: _____

PRIMARY INSURANCE Name of Policy Holder: _____ [] Self [] Spouse [] Parent

Employer_____ Holders Birth Date_____

Business Address_____ Social Security # _____

Dental Insurance Company _____ Group #: _____

SECONDARY INSURANCE Name of Policy Holder: _____ [] Self [] Spouse [] Parent

Employer_____ Holders Birth Date_____

Business Address_____ Social Security # _____

Dental Insurance Company _____ Group #: _____

****** Please present your insurance cards to the front desk ******

Acknowledgment of Accuracy and Consent

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits to which I am entitled. I will not hold Dr. Timian or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature **X** _____

Office Financial Policy- Peter A Timian DMD

636 Lincoln Highway | FAIRLESS HILLS PA, 19030 | (215) 295-8783

Our primary mission is to deliver the best and most comprehensive dental care available. For our patients with dental insurance we are happy to work with your carrier to maximize your benefits.[3] Even with dental insurance, there are always deductibles and co-payments. The care you need may also exceed the benefits available to you.

While we do our best to evaluate the benefits available to you, knowing and understanding your policy and its benefits and limitations is ultimately your responsibility. Dental Insurance plans are ultimately a contract between you and your employer. We do our best to evaluate and estimate your coverage and available benefits, but often, not all details of your plan are available to us as a third party to that contract. Please read below to understand both our office policies, and some definitions of how insurances most commonly work.

All deductibles and co-payments are due in full at the time of service.

We offer the following payment options:

- Payment by Cash
- Payment by Check
- Payment by Visa, MasterCard, Discover Card or Debit Card
- Payment using your Medical Reimbursement Account Card / Flex-Spending Debit Card
- No Interest[1] Payment Plans[2] from CareCredit

CareCredit: Extended payments are only available through CareCredit for treatment plans in excess of $500.00. *[Through CareCredit you may make interest free payments for one year, pending credit approval.]* If you would like to make an application to CareCredit please ask at the desk to fill out the application. We will be happy to help you get the process started.

Secondary Insurance Policy: Effective December 1st, 2012. All copayments and deductibles will be due at the time of service based upon the estimated payments of the primary insurance. As a courtesy we will process the secondary insurance paperwork for you. Any secondary insurance payments will be marked to reimburse you directly. *[Please see the Non-Duplication of Benefits definition below.]*

Rebilling Fees / Collection Action: Effective, December 1st, 2012 all open balances in excess of 60 days will be subject to a monthly rebilling fee of $3.00. Delinquent accounts surpassing 90 days are referred to ***TransWorld Collection Services*** for further action. This action will also result in the addition of collection fees to your account in the amount of $20.00 plus 40% of your balance on account. A fee of $30 will be made for returned checks.

Missed Appointment/Cancellation Fees: A fee of $25 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

DENTAL INSURANCE IS NOT LIKE MEDICAL INSURANCE ~ How it works…

Dental Insurance is a form of benefit that offers patients a supplement to (1) help pay for a portion of their treatment and (2) offers their members a discounted rate over a non-insured individual. Each patient's employer purchases dental insurance for their company. For that reason every single dental plan is different. It is the patient's responsibility to know some very important pieces of information about their contract so you do not encounter any surprises.

Waiting Periods – These are periods of time that must elapse before the insurance company pays a benefit. (These usually occur for new members for 1 year's time and cover major work like; crowns, bridges, dentures, partial dentures etc.)

Replacement Periods - These are the amounts of time that must lapse before the same tooth can receive a benefit. (Example: most crowns/dentures must be 5-10 year old before the insurance company will allow another benefit to be paid.)

Alternative Benefit – This is the downgraded benefit the insurance company pays for another alternative procedure instead of the actual procedure preformed. (This is the biggest area where patients get the most confused. Most insurance companies pay for the back teeth to have "metal" colored fillings and crowns. They may not cover tooth colored or porcelain fillings and crowns. Some insurance companies also pay a lower benefit for bridges if there are multiple missing teeth.)

Missing Tooth Clause – This is what it says. If there was a tooth missing prior to insurance coverage they will not cover for any replacement work such as a bridge, partial denture or implant.

Non-Duplication of Benefits Clause- For those patients who have two insurance carriers, many policies will carry a non-duplication of benefits clause that states the secondary plan will be exempt from making any payment if the primary policy already made payment to the level that their policy would have covered. This often results in no benefits becoming available from the secondary insurance. Secondary insurance most commonly makes payment on procedures that are not part of the primary policy.

Dental Insurance Maximum – This is the maximum amount your insurance company will pay out in a 12 month period. This is for *all* dental work including specialists. The 12 month period may be a calendar year or it may be another 12 month corporate cycle. We do our best to present a good faith estimate on that proposal. However, with the various policy provisions it is impossible for us to provide you with a precise dollar amount.

Benefits Quoted by your carrier are NOT a Guarantee: This fine print is on all of your correspondence from your insurance carrier and will be told to you by customer service representatives. YOUR INSURANCE COMPANY MAY NOT PAY THEIR ESTIMATED PORTIONS as quoted either in writing or verbally.

PRINTED NAME Date

X **UPDATED 02/02/2015**

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2]Subject to credit approval
[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.