Souderton Office
775 Route 113
Souderton, PA 18964
215-723-2162

Harleysville Office
181 Main Street
Harleysville, PA 19438
215-723-1109

Registration:

Patient Name (Last, First, Middle): ___________________________________ Birthdate: _________ / _________ / ________

SS #: _________- __________ - ___________ Preferred Name: ___________________________________ Gender: M / F

Marital Status: S / M / D / W Address: ____

Town: ______________________ State: ______ Zip: __________ E-Mail Address: ________________________________

Please Circle preferred: H. Phone: _______________ W. Phone: __________________ C. Phone: _______________________

Would you like a Text Message appointment reminder? Yes / No Which office location do you prefer? _______________

Employer: ____ Position: ___________________________________

Name of person/family member financially responsible for payment of this account: _______________________

Address of responsible party if different than above: ____

Insurance:

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: ____ Relationship to Patient: ________________________

Address: ____ Town: _____________________ State: _____ Zip: ________

SS # (Required): ___________ - ___________ - ______________ Birthdate (Required): ________ / ________ / ___________

Employer: ____ Work Phone: ______________________________________

Insurance Company: ______________________________ Group #: _____________ Employee ID#: ______________________

Please provide us with your insurance card for our records.

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: ____ Relationship to Patient: ________________________

Address: ____ Town: _____________________ State: _____ Zip: ________

SS # (Required): ___________ - ___________ - ______________ Birthdate (Required): ________ / ________ / ___________

Employer: ____ Work Phone: ______________________________________

Insurance Company: ______________________________ Group #: _____________ Employee ID#: ______________________

Please provide us with your insurance card for our records.

*Office use: Billing Type: _____________ Dr Pref: _______________ Clinic ID:_________
* Insurance: Card Scanned: _____________ Entered into Dentrix: _____________ EC Notation: _________

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

Patient/Parent or Guardian Signature: ____ Date: ______________

Patient Name: ____________________________________ **Date of Birth:** ____ /_____ /_____

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Financial Policy

Our commitment to you is to provide a patient centered experience each time you visit us. We desire to work with patients who are invested in their care and take responsibility for their own health. We will do our best to educate you about your needs and provide options to assist you in making your own choices regarding your dental treatment.

INSURANCE: With our vision for you in mind, we are happy to file insurance claims, work to maximize benefit plans on your behalf, and submit pre-estimates for certain procedures. **However, the ultimate financial responsibility for all dental treatment remains with you, our patient.**

We are **IN- NETWORK** with the following insurance companies: Initial: ______

- Delta Dental Premier Plan
- Cigna PPO

We are **OUT- OF -NETWORK** with all other insurance companies. Initial: ______

Each patient case is unique and we make every attempt to work with you as an individual to customize a treatment plan and financial arrangements that you are comfortable with.

It is customary to pay for all dental treatment at the time of your visit. Any other arrangements must be made in advance.

- You may pay your portion **at the time of your visit** using cash, check, Visa, MasterCard, Discover or American Express, including HSA and FSA accounts.
- Arrangements may be made **in advance** for interest free financing through Care Credit.
- For those patients who have insurance benefits, we will estimate the portion we anticipate is not covered by insurance and will inform you of your expected co-payment that is due when services are rendered.
- **Please keep in mind these are not guarantees of your insurance payment but estimates only.**
- You may set up automatic credit card payments for **pre-arranged** installment plans.
- A statement fee of $5.00 will be applied monthly for accounts not paid in full.

- **I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance to the dentist.**
- **This form also authorizes this practice to submit insurance claims and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE."**
- **I agree to be responsible for payment of all services rendered to me or my dependents.**

I have read and agree to the Weaver, Reckner & Reinhart Dental Associates Financial Policy

Patient/Parent or Guardian Signature: _______________________________________ Date: ________________

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Patient Name: ______________________________ **Date of Birth:** _____ /_____ /_____

Medical Information:

Physician Name ______________________________ Physician Phone Number: ______________________________

Are you under the care of any specialists? *If yes, please list below:*

Specialist Name: ______________________________ Condition being treated: ______________________________

Specialist Name: ______________________________ Condition being treated: ______________________________

If hospitalized in the past 5 years, *when, and for what reason*? ______________________________

Do you/have you ever Pre-medicated for Dental Treatment? *If yes, for what reason?* ______________________________

Have you ever had any of the following? (*Please* **circle/indicate** *the specific option that applies)*

Yes	No	Condition	Yes	No	Condition
❑	❑	Heart Attack	❑	❑	Diabetes
❑	❑	Heart Murmur	❑	❑	Glaucoma
❑	❑	Mitral Valve Prolapse	❑	❑	Epilepsy/Seizures/Fainting Spells
❑	❑	Heart Surgery/Bypass	❑	❑	Fever Blisters/Herpes
❑	❑	Pacemaker/ICD	❑	❑	Headache/Migraines
❑	❑	Heart Valve Replacement	❑	❑	Hearing Problems
❑	❑	Heart Arrhythmia/ A-Fib	❑	❑	Hemophilia/Abnormal Bleeding
❑	❑	Heart Defect	❑	❑	Hepatitis/ Type
❑	❑	High or Low Blood Pressure	❑	❑	High Cholesterol
❑	❑	Anxiety	❑	❑	HIV+/AIDS
❑	❑	Depression	❑	❑	Learning Disability
❑	❑	Eating disorder	❑	❑	Stomach Issues/Acid Reflux/GERD
❑	❑	Mental Illness	❑	❑	Kidney Problems
❑	❑	Asthma	❑	❑	MRSA
❑	❑	Emphysema	❑	❑	Osteoporosis
❑	❑	Bronchitis, etc.	❑	❑	STD/HPV
❑	❑	Alcoholism	❑	❑	Other Infectious Disease; Please specify: __________
❑	❑	Drug Addiction	❑	❑	Sinus Problems
❑	❑	Anemia	❑	❑	Smoker, cigars, vape, chewing tobacco
❑	❑	Joint Replacement/Surgery	❑	❑	Stroke
❑	❑	Arthritis	❑	❑	Tuberculosis (TB) When?
❑	❑	Autism/ASD/Asperger's	❑	❑	Ulcers/Colitis/C-Dif
❑	❑	ADD/ADHD	❑	❑	Thyroid Problems/Adrenal/Pituitary
❑	❑	Blood Transfusion	❑	❑	Muscle/Nerve Disease
❑	❑	Cancer; please specify: ____________________	❑	❑	Autoimmune Disease
❑	❑	Chemotherapy and/or Radiation	❑	❑	Blood Thinners? Please specify: ____________________
❑	❑	Chromosomal Abnormality	❑	❑	Other; Please specify: ____________________

Current Medications: ** Please list **all medications**, including dosage and frequency, below**

Prescription Medications: ____

____

____

____

____

Over the Counter Medications/Supplements: ____

____

____

____

Patient/Parent or Guardian Signature: ______________________________ **Date:** ____________________

Continued on other side →

Patient Name: ______________________________ **Date of Birth**: _____ /_____ /______

Allergies: Are you allergic to any of the following?

- ❑ No Known Allergies
- ❑ Aspirin ____________________
- ❑ Penicillin ____________________
- ❑ Latex ____________________
- ❑ Dental Anesthetics ____________________
- ❑ Jewelry/Metal/Nickel ____________________
- ❑ Tetracycline ____________________
- ❑ Codeine ____________________
- ❑ Erythromycin ____________________
- ❑ Other allergies: ____________________

For Women:
Please indicate if any of the following apply:

- ❑ Taking Birth Control Pills
- ❑ Pregnant
  If yes, *Due Date:* __________________
- ❑ Nursing

Have you ever taken **Bisphosphonates**? Yes No
(Boniva-Fosamax-Actonel-Skelid-Didronel-Aredia-Zometa-Reclast)
____

For your Child: Does your child have any of the following **Dental Habits**:

- ❑ Suck Thumb/Finger
- ❑ Clench/Grind Teeth
- ❑ Use Pacifier
- ❑ Suck or Bite Lips/ Tongue or Chew Cheek
- ❑ Tongue Thrust
- ❑ Mouth Breather
- ❑ Bite/Chew nails
- ❑ Other: _____________

Your Child's Hygiene Routine: (Check all that apply)

- ❑ Daily Prescription Fluoride
- ❑ Dental Floss ___ times/day
- ❑ Fluoride Toothpaste
- ❑ Fluoride Mouthwash
- ❑ Brushing ___ times/day
- ❑ Fluoridated Water

Dental History:

What brings you to see us today? ____

Previous Dentist Name: ____

Have you ever had a serious/difficult problem associated with any dental work? Yes No

If yes, please explain: ____

If you could change one thing about your smile, what would it be? ______________________________

____

Please indicate the level of dental care you would like us to provide:

- Emergency care as needed ❑
- Comprehensive care, optimal dental health and appearance ❑
- Routine exam and preventative care ❑
- Consultation to solve a specific problem ❑

- ❑ Have you had your wisdom teeth removed?
- ❑ Do you have dental implants?
- ❑ Have you ever whitened your teeth?
- ❑ Have you ever had Botox/facial filler?
- ❑ Do you snore?
- ❑ Do you grind your teeth?
- ❑ Have you ever had braces?
  Orthodontist Name: _______________________
- ❑ Do you get a burning sensation on tongue?
- ❑ Do you ever have jaw pain?
- ❑ Do you wear a dental appliance?
- ❑ Do your gums ever bleed?
- ❑ Have you had any periodontal (gum) treatment?
- ❑ Are you a mouth breather?
- ❑ Do you use a C-Pap Machine?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Parent or Guardian Signature: ______________________________ **Date:** __________________

Patient Name: ____ **Date of Birth:** ____ /____ /____

Weaver, Reckner & Reinhart Dental Associates

Electronic Communications Patient Consent Form

Weaver, Reckner & Reinhart Dental Associates cannot guarantee, but will use reasonable means to maintain the security and confidentiality of electronic communications such as email or text messages. We take appropriate precautions when transmitting electronically to avoid unintentional disclosures, such as verifying your e-mail address or text number for accuracy before sending. The Practice is not liable, however, for improper disclosure of confidential information that is not caused by our intentional misconduct.

The Risks of Using Electronic Communications

Transmitting patient information electronically can be risky. Please consider the following possibilities before agreeing to communicate with us in this way. For example, messages can be intercepted, viewed, circulated, altered, forwarded, stored or used without authorization or detection. In addition, messages may be misaddressed, read by employers and online service providers, easily falsified, retained after deletion, used to introduce viruses, or used as evidence in court.

Still Want To Use Electronic Communications?

If you want to use email, texting, etc. to communicate with us, we have some final instructions:

- We cannot guarantee your communications will always be read promptly, so please do not use these methods for urgent matters.
- Be sure to follow-up with us by phone if you are expecting a return response from us and do not receive one within 2 business days.
- Please notify us promptly if your email address, text number, etc. has changed.
- Be aware that most electronic communications from patients become a part of their health record.
- Do not use these methods to share sensitive medical information, such as communications about AIDS/HIV or mental health conditions, sexually transmitted diseases or substance abuse.

I understand the risks associated with electronic communications of personal health information, dental procedures, appointment information, treatment fees, billing information and give my consent for the practice to communicate with me through **text messaging**, **email**, and **phone call**.

If I have any questions, I will contact the Practice Privacy Officer.

Patient Signature: ____________________________ ***Print Name***: ________________________

Personal Representative: _________________________ *Print Name:* ______________________

Date: ______ / _______ /_______

Note: ____

** ___ I decline the use of Electronic Communication *Patient Signature:*___________________

*** I would like to opt out of communication via ____ text messaging ____ email ____ phone call

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Weaver, Reckner & Reinhart Dental Associates

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, ______________________________, have received a copy of WRR's "Notice of Privacy Practice", which describes how my dental, health, and financial related information* is used & shared. I understand that the practice has the right to change this notice at any time. I may obtain a current copy by contacting the privacy officer.

____ ________________

Signature of patient or parent/guardian Date

1.____ _________________

Name of individual to whom we may disclose your *information Relationship

2.____ _________________

Name of individual to whom we may disclose your *information Relationship

3.____ _________________

Name of individual to whom we may disclose your *information Relationship

4.____ _________________

Name of individual to whom we may disclose your *information Relationship

FOR OFFICE USE ONLY

We attempted to obtain a 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

EMERGENCY CONTACT

Name: _________________________________ Phone Number: ____________________ Relationship: ______________

- I authorize the practice to take all necessary diagnostics, including x-rays. I authorize the practice to treat my dental needs using anesthetics or medications if necessary and am fully aware that these may involve risks.
- I authorize appointment reminders such as voicemail messages, postcards, letters or e-mail confirmations.
- I authorize my dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier, staff, hospitals or other medical practices as necessary and/or requested.

Patient/Parent or Guardian Signature: _______________________________________ Date: ___________________

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