Dr. Raya Ben Dor
650 Vally Forge Road
Phoenixville, PA 19460
(610) 933-8139

WELCOME TO STARR VALLEY DENTAL!

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Patient's Date of Birth: _____

Patient's Address: _____ Patient's Social Security #: _____

_____ Patient's Phone #: _____

_____ Cell Phone #: _____

Patient's Age: _____ Sex: _____ Email: _____

RESPONSIBLE PARTY

Responsible Party: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Phone#: _____

_____ Cell Phone #: _____

Relationship to Patient: _____ Work Phone #: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone: _____

Address: _____ Union or Local #: _____

_____ Group #: _____

Insurance Company: _____ Phone #: _____

Address: _____ Member #: _____

_____ Family/Single Coverage: _____

ADDITIONAL INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Employer: _____ Social Security #: _____

Insurance Company: _____ Date of Birth: _____

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Starr Valley Dental

MEDICAL HISTORY FORM

Patient's Name:_____

Date:_____

PLEASE CHECK THE APPROPRIATE ANSWER. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND ARE CONFIDENTIAL.

	Yes	No
1. Are you in good health? ……	☐	☐
2. Are you currently under medical care? ……	☐	☐

If so, what's the condition being treated?_____

Date of last physical exam_____

3. Has there been any change in your health within the past year?	☐	☐
4. Have you ever had a serious illness or operation?	☐	☐
5. Have you ever had abnormal bleeding after an accident, surgery, or having a tooth pulled?	☐	☐
6. Have you ever required a blood transfusion?	☐	☐
7. Have you ever had surgery or x-ray (radiation) treatment for a tumor, growth, or other condition?	☐	☐
8. Do you have or have you ever had any of the following?		
a. Rheumatic fever or rheumatic heart disease	☐	☐
b. Heart abnormalities present since birth	☐	☐
c. Heart murmur	☐	☐
d. Mitral valve prolapse	☐	☐
e. Artificial joint prosthesis	☐	☐
f. High blood pressure	☐	☐
g. Heart attack……	☐	☐
h. Stroke	☐	☐
i. Bypass surgery	☐	☐
j. Pacemaker	☐	☐
k. Angina (chest pain)	☐	☐
l. Congestive heart failure	☐	☐
m. AIDS/HIV	☐	☐
n. Anemia, sickle cell anemia, or other		
o. bleeding disorder	☐	☐
p. Asthma	☐	☐
q. Cancer	☐	☐
If yes, what kind?_____		
r. Diabetes	☐	☐
s. Drug or alcohol abuse	☐	☐
t. Epilepsy, seizures, or fainting spells	☐	☐
u. Glaucoma	☐	☐
v. Hepatitis or liver disease	☐	☐
w. Kidney disease	☐	☐
If yes, do you receive dialysis?	☐	☐
x. Lung disease	☐	☐
y. Stomach ulcers	☐	☐
z. Thyroid problems	☐	☐
aa. Tuberculosis	☐	☐
bb. Venereal disease	☐	☐

Any disease, condition, or problem not listed? ☐ ☐
If yes, please explain:

_____

_____

Medical Doctor's Name:_____
Medical Doctor's Address:_____

_____
Medical Doctor's Phone:_____

Are you taking any of the following?	**Yes**	**No**
a. Antibiotics	☐	☐
b. Blood thinners (Coumadin, Warfarin, Plavix)	☐	☐
c. Medicine for high blood pressure	☐	☐
d. Steroids (cortisone, prednisone)	☐	☐
e. Aspirin or NSAID's (Motrin, Advil, etc.)	☐	☐
f. Dilantin or other anti-seizure medicine	☐	☐
g. Insulin or other drug(s) for diabetes	☐	☐
h. Digitalis or drugs for heart disease	☐	☐
i. Nitroglycerin	☐	☐
j. Narcotics (pain pills)	☐	☐
k. Birth control	☐	☐
l. Do you smoke?		
If yes, How much?.....How often?.....	☐	☐
Do you drink alcohol?		
If yes, How much?.....How often?.....	☐	☐

PLEASE LIST ALL CURRENT MEDICATIONS

_____
_____
_____
_____

Are you allergic or have you ever reacted adversely to:		
a. **Local anesthetics (Novocaine, etc.)**	☐	☐
b. **Penicillin or other antibiotics**	☐	☐
If other antibiotics, please specify_____		
c. **Aspirin**	☐	☐
d. **Codeine or other narcotics**	☐	☐
e. **Latex**	☐	☐
f. **Other**……		

WOMEN:

Are you or could you be pregnant?	☐	☐
Are you presently breast feeding?	☐	☐

The undersigned agrees that the information above is correct.

_____ _____
Patient's Signature Date

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Starr Valley Dental

FINANCIAL POLICY

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits. You are responsible to know your plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as a missing tooth, crown/bridge/denture restorations, bruxism, downgraded limitations for filling and porcelain on crowns on molar teeth. Frequency limits for exams, prophylaxis, fluoride and x-rays etc.
The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, or Discover. To help you accept an extensive treatment plan, we are offering a Care Credit dental treatment Financing Program. All estimates are subject to final approval by your dental insurance plan. Therefore the amount due is subject to change after final explanation of benefits have been paid. (Initials) _____

INTIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam cleaning. No deductible is due for diagnostic or preventative treatment unless otherwise stated. There are some Plans with coinsurance payment for x-rays and dental exams. Deductibles for basic/major services customarily include fillings, crowns, extractions, root canal therapy and periodontal treatment.

FINANCIAL CHARGES: All returned checks are subject to $25 fee. All balances over 90 days are subject to interest in amount of 1.5% per month mandated by State law. We reserve the right to apply $20 rebilling fee and $25.00 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau. (Initials) _____

PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all the fees including and not limited to attorney fees, court costs, and collection agency fees. (Initials) _____

MISSED APPOINTMENT FEE: Please note that there is a missed appointment fee of $50.00 per hour for all appointments canceled without at least 24 business hours' notice. Please give us a call in advance if you need to reschedule or cancel your appointment.
(Initials) _____
This is an Agreement between Starr Valley Dental, as a provider of professional services and creditor, and the patient/debtor named on this form. By reading and signing this Agreement, you are agreeing and accepting this policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION: ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF STARR VALLEY DENTAL.

Print Name _____ (PATIENT/SUSCRIBER, if minor-Guardian)

SIGNATURE _____ DATE _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____