PATIENT INFORMATION

Patient's Name: _____

If Child: _____ (NAME OF PARENT OR GUARDIAN) SS #: _____ Birth Date: _____

Patient's Birth Date: _____ Sex: ☐ M ☐ F Patient's SS #: _____

Home Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone No.: _____ Work Phone No.: _____

Who referred you to our office? _____

INSURANCE INFORMATION

Is your dental coverage paid by a dental plan or insurance? ☐ YES ☐ NO
(If YES, please fully complete below. If NO, complete employer information ONLY)

PRIMARY Subscriber Home Phone #: _____ Subscriber Work Phone #: _____

Subscriber's Name: _____ Birth Date: _____

SS #: _____ Occupation: _____

Employer's Name: _____

Employer's Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Insurance Co. Name: _____ ID/Group No.: _____

Agreement No.: _____ Deductible: $ _____ Maximum: $ _____

Relationship to Patient: _____ Benefit Year Begins: _____ (MONTH/YEAR)

SECONDARY

Subscriber's Name: _____ Birth Date: _____

SS #: _____ Occupation: _____

Employer's Name: _____

Employer's Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Insurance Co. Name: _____ ID/Group No.: _____

Agreement No.: _____ Deductible: $ _____ Maximum: $ _____

Relationship to Patient: _____ Benefit Year Begins: _____ (MONTH/YEAR)

MEDICAL HISTORY

	YES	NO
Are you currently under the care of a Physician (Name)?	☐	☐
If YES, Name and Phone # of the Physician.		
Are you taking any medication (List) ?	☐	☐
Are you allergic to any medication(s) (List)? (which medication)	☐	☐
Are you pregnant? Could you be pregnant?	☐	☐

Do you have any history of the following?

	YES	NO		YES	NO
Heart Trouble	☐	☐	**Abnormal Bleeding**	☐	☐
Mitral Valve Prolapse	☐	☐	**Stomach Problem or Ulcer**	☐	☐
Heart Murmur	☐	☐	**Diabetes**	☐	☐
Rheumatic Fever	☐	☐	**Hepatitis**	☐	☐
Heart Valve Replacement	☐	☐	**AIDS**	☐	☐
Hypertrophic Cardiomyopathy	☐	☐	**Tuberculosis**	☐	☐
High Blood Pressure	☐	☐	**Cancer or Radiation Therapy**	☐	☐
Stroke	☐	☐	**Knee or Hip Replacement**	☐	☐

Are there any other medical conditions we should know about? _____

_____

X _____
SIGNATURE

Steven E. Cross D.D.S.
532 Baltimore Pike
Springfield, PA 19064
(610) 328-6618

FINANCIAL POLICY

PATIENTS WITH INSURANCE COVERAGE

We will be glad to help you obtain the appropriate benefits from your insurance carrier and bill your carrier as a courtesy to you, however, you are responsible for payment of the account.

We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting for a pre-estimate of benefits.

Portions of your bill may not be covered by the insurance carrier and are to be paid by the patient. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double coverage (if you and your spouse both have dental plans) there may still be a portion that will be your responsibility.

If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our receptionist will assist you in arranging a payment schedule.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are requested to pay for services as rendered. We accept Visa, Mastercard, Discover and American Express cards as payment.

ADDITONAL TERMS

It is very difficult to arrange our schedule effectively when appointments are cancelled without 24 hours prior notice. **Appointments cancelled with less than 24 hours notice are subject to a $40.00 cancellation charge.** If your account is referred for collections, you are responsible for coleection costs, together with attorney's fees. There will be a charge of $35.00 for any check returned from the bank.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR. STEVEN E. CROSS D.D.S.

X_____ _____

Signature of patient/guardian Today's date