Dr. Jenny Chen Pediatric and Family Dentistry Patient
Update Information:

Patient Name: _____
If child provide parent/ guardian information _____

Birth Date: _____ Age: _____ Male Female SS#_____

Home Address: _____City/State/Zip: _____

Home Phone #:_____ Work Phone: _____

Cell Phone #: _____ Employer: _____

Email address: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact Person: _____ Phone :_____

Responsible Party Information: (If ***not*** the patient please complete)

Parent or Spouse Name: (circle one) _____

Address: (if different from above) _____

Phone #:_____ Cell Phone #:_____ Is this person currently a patient? Y or N

Birth Date: _____SS# _____

Employer: _____ Work Phone: _____

Insurance Information: (If ***other than*** patient or responsible party please complete below)

Please Present office with your insurance card.

Insured's Name: _____ SS#:_____ Birth Date: _____

Employer: _____ Work Phone:_____

Do you have secondary coverage? Please present office with that insurance card as well.

Insured's Name: _____ SS#:_____ Birth Date: _____

Employer: _____ Work Phone #:_____

Authorization and Release

Our dental office will gladly assist you in filing your insurance claim, but we are unable to accept responsibility for collecting your claim if there is a dispute. It is your responsibility to pay for the entire amount not covered by your dental benefit plan. By signing this form, you hereby assign all payments for services provided for yourself or dependents to Dr.Jenny Chen Pediatric and Family Dentistry. TIME OFF REQUEST FORM
All accounts 30 days and over are past due and will be subject to an interest rate of 18% per annum. All collections 90 days past due may be turned over for collection. In the event, you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees.

_____

Responsible Party's Signature **Date**

Patient Medical History:

Physician's Name: _____ Phone #:_____ Date of last visit:_____

How long since your last: Dental Visit: _____ Cleaning: _____ X-rays:_____

1. Are you under medical treatment now? Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No

3. Are you taking any medication(s), including non-prescription medications or diet pills? Yes No

Please List:

4. Do you use alcohol? Yes No Tobacco? Yes No

5. Are you nursing? Yes No

6. Are you allergic to or have any reactions to the following?

Local Anesthetics (e.g. Lidocaine)	Yes	No
Penicillin or other Antibiotics	Yes	No
Latex	Yes	No
Narcotic Drugs (e.g. codeine)	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Metal or Other_____	Yes	No

7. Women Only: Are you pregnant or think you may be pregnant? Yes No

8. Are you taking birth control medications? Yes No

Do you have or have you had any of the following? (Explain below)

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Hay Fever/Allergies	☐	☐	Angina	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Respiratory Problems	☐	☐	Radiation Therapy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Recent Weight Loss/Gain	☐	☐	Cancer	☐	☐
Artificial Heart Valve	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Mitrovalve Prolapse	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Asthma	☐	☐
AIDS/HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Diabetes	☐	☐
Thyroid Problems	☐	☐	Stomach Problems/Ulcers	☐	☐	Leukemia	☐	☐

Other: _____

Explanation: _____

Patient Dental History: Circle your answer

1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold foods/liquids?
3. Are your teeth sensitive to sweet or sour foods/liquids?
4. Do you have any sores or lumps in or near your mouth?
5. Have you had any head or neck injuries?
6. Have you ever experienced any of the following problems in your jaw?
   - Clicking
   - Pain (joint, ear, side of face)
   - Difficulty in opening or closing
   - Difficulty in chewing
7. Do you have frequent headaches?
8. Do you clench or grind your teeth?
9. Have you ever had any difficult extractions?
10. Did you wear braces?
11. Have you had any prolong bleeding following an extraction?
12. Have you ever had instruction on the correct method of brushing your teeth or care of your gums?

I certify that I have completed the above information to the best of my knowledge.

Signature of Patient or Parent Date

Jenny Chen Pediatric and Family Dentistry
207 North Guernsey Road
West Grove, PA 19390

Authorization for Signature on File
Release of Information/Financial Responsibility/Assignment of Benefit

I_____ hereby authorize the office of Jenny Chen Pediatric and Family Dentistry to affix my name to any and all claims or documents as related to any and all health benefits for me and my dependents. I hereby authorize payment of dental benefits otherwise payable to me directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorized release of any information relating to the claim.

Limited Power of Attorney

This Dental Office is authorized to fill out and/or to assist me to complete any and all insurance forms pertaining to services rendered. This Dental Office is also authorized to sign my name to insurance forms when payment is due to them if not present to sign at the time of completion of the form.

Financial Policy

I understand that I am financially responsible for all services rendered by the Dentist unless prior arrangements have been made. These services must be paid for at the time of treatment. If I have Dental Insurance, I must make proper co-payments at the time of treatment, and I am totally responsible for anything the insurance company does not pay within 45 days after billing. This "Authorization" will be valid from this date and shall expire in two years. A photocopy of this document may act as an original. If payment for service is not paid after 45 days your account may be sent to IC collection agency, a 33% additional charge will be added to your account to pay for collection fee.
Lab cases such as (crowns/bridges/dentures) are time sensitive. Any lab case that is not received by the patient within a three month period can lead to remake of the restoration. If a remake has to be done the patient will be responsible for a remake fee which can vary depending on each particular lab cases.

RE: Broken Appointments

Definition: A scheduled appointment is considered a broken appointment when the patient:

1. Cancels the appointment with less than 24 hours' notice
2. Fails to keep the appointment (No Show)

Broken appointment charge

The time the dentist set aside for a patient is very valuable. Broken appointments make it difficult for our office to maintain a schedule that is efficient for staff and convenient for our patients. For this reason, patients may be charged for broken appointments. This charge is not a penalty but an attempt to maintain the fair compensation for the time needed for care, and the cost of that time. The doctor has limited amounts of appointment times and this time should not be wasted. Please help up provide quality dental care at affordable prices by coming on time for your appointments.

I understand there is between **$25.00** to **$50.00** for a broken appointment.

HIPPA

I am aware that this office is HIPPA compliant

Signature of Patient: _____Date_____
(parent or guardian if minor)