NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle): _____ TITLE: _____

ADDRESS: _____

PREFERRED NAME: _____ SS NO: - - DOB: / /

HOME PHONE: _____ MARITAL: S/M/D/W REF. DOCTOR: _____

WORK PHONE: _____ SEX: M / F REF. PATIENT: _____

CELL PHONE: _____ EMAIL: _____

MEDICAL ALERTS: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS : _____

PLAN NAME: _____ GROUP NO: _____ IND YRLY DEDUCT: _____

INSURANCE CO: _____ FAM YRLY DEDUCT: _____

ADDRESS: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS : _____

PLAN NAME: _____ GROUP NO: _____ IND YRLY DEDUCT: _____

INSURANCE CO: _____ FAM YRLY DEDUCT: _____

ADDRESS: _____

MEDICAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

RESPONSIBLE PARTY

NAME AND ADDRESS: _____

SIGNATURE: _____

Your Smile

"Our primary goal is for you smile to be healthy"

We also believe everyone deserves to have a beautiful smile. They say "beauty is in the eye of the beholder". Please take a moment to share your thoughts about your smile with us.

When you look at your smile are you: Very Dissatisfied Dissatisfied Satisfied Very Satisfied

What do you like about our smile?

Is the color of your teeth: Not as white and bright as you would like or Perfect for you?

What changes have you noticed in your smile over the last several years?

When you notice other smiles, what do you like about them?

What changes would you like to make in your smile and when would you like to start them?

When you see smile enhancement advertisements that interest you, specifically what appeals to you?

If you have considered enhancing your smile in the past, what has prevented you from doing so?

Would you be interested in beautifying your smile if it could be done comfortably and be made affordable for you?

Please tell us what changes in your smile are most important to you?

Would you be interested in having a photo taken to be imaged with a cosmetic option?

Comfort Menu

Your comfort is very important to us. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

•Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?.....Yes☐ No☐
•Heated neck wraps keep you comfortable and warm through your visit.
Would you like a neck wrap?.....Yes☐ No☐
•Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?.....Yes☐ No☐
•We provide DVD's and video glasses for longer procedures(or you can bring your own)
Would you like to watch a DVD?.....Yes☐ No☐
•We have noise-cancelling headphones or feel free to bring your own mp3 players.
Would you like noise-cancelling headphones?.....Yes☐ No☐
•Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other_____
•We provide various levels of sedation to ease your mind.
Would you benefit from a sedative?.....Yes☐ No☐
If yes, we provide:
☐ Mild sedative (oral medication) With mild sedative, you will need someone to drive you to and pick you up from your appointment
•Is there anything else we can do for you to make your visit comfortable?

_____

Please place a check mark in the box next to the statements that concern you or describe your problem.

☐ I gag easily.
☐ I don't like cotton in my mouth.
☐ I have not been to the dentist for a long time and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
☐ Please tell me what I need to know about my mouth in order to make an informed decision. I like to have as much information as possible.
☐ I want to know the cost up front. No money surprises please.
☐ I have health problems and questions that we need to discuss
☐ I hate the noise of the drill.
☐ Please respect my time. I don't want to be left sitting in the reception area.
☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
☐ I feel out of control when I'm lying down in the dental chair.
☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
☐ Pain relief is a top priority for me.
☐ I don't like shots (or I've had a bad reaction to shots).
☐ My teeth are very sensitive.

GORDON M. BELL, DDS, FICOI, FAGD, DABDSM
KAITLYN A. KATHERMAN, DMD

450 W. Market Street
Hellam, PA 17406
(717) 757-4878

Financial Policy

The following is the financial policy for Dr. Bell and Dr. Katherman

1. **Patients with dental insurance coverage:**

   Our office **does not** participate with any dental insurance plans. **Payment in full** is expected at the time of service. We will submit all dental claims for our patients as a courtesy. Because of our non-participating status, some insurance companies will not send the payments to our office; these payments will be mailed directly to the patient (subscriber). Patients who pay **in full** the date services are rendered will receive a 5% discount with cash or check and 2% for credit for any balances over $500.00. Sr. Citizens receive 5%. Payment arrangements for extensive cases will be discussed with the treatment coordinator. Our office also works with Care Credit.

2. **Patients without dental insurance coverage:**

   Patients without dental insurance coverage are responsible for **payment in full** at the time of service. Patients who pay **in full** will receive a 5% discount with cash or check and 2% for credit for any balances over $500.00. Sr. Citizens receive 5%. Payment arrangements for extensive cases will be discussed with the treatment coordinator. Our office also works with Care Credit.

3. **Delinquent accounts:**

   It is our policy that delinquent accounts will be sent to a third party for collection. The balance due on the account plus a collection fee is the amount that will be mailed to the collection agency.

   We accept checks, cash or debit/credit cards.

   Thank you in advance,

   Gordon M. Bell, DDS
   Kaitlyn A. Katherman, DMD

Signature: _____ Date: _____
Print Name: _____