BEYOND DENTISTRY
Comprehensive Oral Health

Rachel L Lewin, DDS & George Federici, DDS
858 Welsh Road, Suite 3 | Maple Glen, PA 19002
(O) 215-643-3755 | (F) 215-646-5135
Email: Info@BeyondDentistryMapleGlen.com
www.BeyondDentistryMapleGlen.com

Today's Date: _____ /_____ / _____ Chart #: _____

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ /_____ / _____ Gender _____

Height _____ ft. _____ in. Weight _____lbs. Hobbies: _____

Mailing Address: _____

_____

CITY STATE ZIP

Cell Phone # _____ Home Phone # _____

Email address: _____ SSN#: _____

Would you like to receive text messages? Y | N Emails? Y | N

Marital Status: _____ Spouse/ Partner's Name: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Dental Insurance Information

Fill out if applicable. Please bring your current dental insurance card with you if you have one.

Primary

Name of Insured: _____

Date Of Birth of Insured: _____ /_____ / _____ Employer: _____

Relation: _____ SSN#: _____

Insurance Company: _____ Plan Name: _____

Group Number: _____ ID Number: _____

Please let us know if you have a secondary insurance policy and provide the appropriate information.

Responsible Party- Person responsible for payment of this account

Name: _____ Relation: _____

Mailing Address: _____

_____

CITY STATE ZIP

Cell Phone # _____ Home Phone # _____

Email address: _____ SSN#: _____

Who can we thank for your referral? _____

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Medical History

Name: _____ Date of Birth: _____ /_____ / _____

Are you currently seeing a physician regularly for reasons other than a yearly checkup? Y | N

If yes, who is/are your physician/s and what medical condition/s are they monitoring:

_____

Within the last 5 years, have you ever been hospitalized or had a major operation? Y | N

If yes, please describe: _____

Do you currently have or have you ever had any of the following?

Y N Acid Reflux / GERD
Y N Alcohol / Drug Abuse
Y N Anaphylaxis
Y N Arthritis / Rheumatism
Y N Artificial Joints
Y N Asthma
Y N Back / Neck Problems
Y N Bisphosphonate use
Y N Blood Disorders (Ex: Anemia, Clotting Disorders)
Y N Blood Pressure (High)
Y N Blood Pressure (Low)
Y N Cancer / Tumors
Y N Chemotherapy or Radiation
Y N Cold Sores
Y N Diabetes (Type 1 or Type 2?) (latest HbA1c: _____%)
Y N Fainting Spells / Dizziness
Y N Frequent Neck Pain
Y N Frequent / Severe Headaches or Migraines
Y N Glaucoma
Y N Heart Problems (Ex: Angina, Arrhythmia, Valve Defects)
Y N High Cholesterol
Y N History of Heart Attack / Stroke
Y N HIV+ / AIDS / ARC
Y N Jaw Problems / TMD
Y N Kidney Disease (Ex: Dialysis)
Y N Leukemia
Y N Liver Disease (Ex: Cirrhosis, Hepatitis)
Y N Osteoporosis
Y N Pacemaker
Y N Psychiatric Care
Y N Radiation Treatment
Y N Respiratory Problems (Ex: Shortness of Breath, COPD, Emphysema)
Y N Sexually Transmitted Infection (Ex: HPV, Herpes)
Y N Scarlet / Rheumatic Fever
Y N Seizures / Epilepsy
Y N Shingles
Y N Sinus Problems
Y N Sleep Apnea (OSA)
Y N Stomach Problems / Ulcers
Y N Thyroid or Parathyroid Disease
Y N Tuberculosis (TB)
Y N Other (Please describe below

_____

_____

_____

Have you received your COVID-19 Vaccine(s)? Y | N Booster(s)? Y | N
Please specify latest date & type: _____

ALLERGIES: Are you allergic to any of the following? ☐ NO KNOWN ALLERGIES

☐ Acrylic
☐ Amoxicillin
☐ Aspirin
☐ Codeine
☐ Dyes found in foods (ex: Red Dye)
☐ Latex
☐ Local Anesthetics (specify)
☐ Metals (specify)
☐ Penicillin
☐ Seasonal Allergies
☐ Sulfa Drugs
☐ Tetracyclines
☐ Other:
_____
_____
_____

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Medical History (continued)

OTHER:

Do you now or have you ever used tobacco? (Ex: smokeless (snuff, chew, dip), cigars, vaping) Y | N

IF YES: What type? _____ How much/often? _____ For how many years? _____

IF NO LONGER USING TOBACCO/TOBACCO PRODUCTS: When did you quit? _____

Would you like information on Tobacco Cessation resources? **Y | N**

Do you now or have you ever used controlled substances (including Medical Marijuana)? Y | N

IF YES: Type: _____ How much/often? _____ For how many years? _____

IF NO LONGER USING: When did you quit? _____

For Women:

Do you currently use hormonal contraceptives? **Y | N** (If yes, what kind?) _____

Are you currently or could you be pregnant? **Y | N** Due Date & OB/GYN? _____

Are you currently nursing? **Y | N**

Have you ever taken a bisphosphonate medication (commonly used for bone loss) by pill form, injection, or intravenously? Examples include Fosamax, Prolia, Boniva, Actonel. **Y | N**
IF YES:, please detail which medication(s) & the dates that you took them, as well as date of last dose:

_____

ANTIBIOTIC PROPHYLAXIS / PREMEDICATION:

Do you require antibiotics prior to dental appointments? Y | N

Reason: ☐ Artificial heart valve/ congenital heart defect ☐ Joint Replacement ☐ Other

Prescribing Physician's name and phone number: _____

Antibiotic used for Premedication & Dose: _____

If for joint replacement: which joint/s was/were replaced & when, and who is your orthopaedic surgeon?

_____

Is there any additional information that you feel we should know about your health?

_____

_____

_____

_____

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Please list any and ALL medications & supplements you are currently taking, including dosages and which condition(s) they are for, if you know them (please attach a separate list, if needed):

_____

_____

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_____

By signing this form, I acknowledge that it is complete and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

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HIPAA Compliance & Notice of Privacy Practices Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice reserves the right to change the privacy policy as allowed by law.
- The Practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the member(s) allowed & their relation to you:

NAME: _____ RELATIONSHIP_____

NAME: _____ RELATIONSHIP_____

NAME: _____ RELATIONSHIP_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

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BEYOND DENTISTRY'S FINANCIAL & INSURANCE POLICIES

Thank you for choosing Beyond Dentistry to be your dental care provider; we look forward to offering you and your family the best dental care available. The following is our financial policy that we require all patients to review and acknowledge receipt of prior to any treatment being rendered:

Prior to the start of any services, we will inform you of your treatment options and financial options as requested. This will help you understand your treatment, what to anticipate in fees, and will allow you time to make financial arrangements if needed.

In general, your signature below indicates that you understand and acknowledge the following:

- **Full payment is due at the time of service, unless by previous arrangement.** For your convenience, we accept payment in the form of cash, check, credit card, or one of our financing options such as an in-office automated payment plan (when arranged prior to the date of service).
- Any estimate given to you about the cost of your treatment cannot be guaranteed, as conditions may change during the course of treatment. In the event of a large change in expected cost, the provider will inform you as soon as possible so that you may choose which option is right for you.
- **Beyond Dentistry requires at least 24 hours' advance notice of any changes to or cancellation of your reserved appointment times**. If appointments are cancelled less than 24 hours in advance or are missed, you may incur a $100 charge for each incident barring extenuating circumstances.

For Patients With Insurance: As a courtesy, Beyond Dentistry will submit your claim to your insurance company on your behalf. You authorize your insurance company to pay your benefits directly to you as reimbursement. Furthermore, you understand and acknowledge the following:

- You are fully responsible for any outstanding prior balances on your account
- Payment in full is due on the date that service is rendered, unless by previous arrangement
- Any estimate of your out of pocket costs, including but not limited to "pre-determinations", "prior authorizations", etc. , is not a guarantee of reimbursement from your insurance
- It is your responsibility to be aware of your individual policy limitations and requirements and inform us of them in a timely manner

Furthermore, you understand that if your insurance company sends payment to Beyond Dentistry, we will make all attempts to forward the payment to you within 48 hours or credit your account if that is not possible for any reason. If payment is not received by either you or your insurance company and the office is forced to proceed with the collections process, you will be responsible for any and all costs incurred by the office to retrieve payment for treatment rendered.

By signing this form, I acknowledge that I have read, understand, and agree to the terms and conditions of this financial agreement. A copy of this notice is available to you upon request.

_____ _____

Patient/Parent/Guardian/ Financially Responsible Party Signature Date