Dr. Alexandra S. George DDS, PC
171 Wexford Bayne Road
Wexford, Pennsylvania 15090
(724)934-3422
Enhance Your Smile..... Enhance Your Life

Patient Information

Date_____ Home Phone (____)_____ Cell Phone (____)_____

Name (last,first,middle)_____ SS/HIC/Patient ID #_____

Address_____ E-Mail_____

City_____ State_____ Zip Code_____

Sex (circle) Male Female Age_____ Birth date _____

(Check) O Married O Widowed O Single O Minor O Separated O Divorced O Partnered for____ years

Patient Employer/ School_____Occupation_____

Employer/School Address _____Work Phone (____)_____

Whom may we thank for referring you? _____

In case of an emergency who should be notified?_____ Phone (____)_____

Primary Insurance

Person Responsible for Account (last,first,middle)_____

Relation to patient_____ Birth date_____ ID#/Soc. Sec. #_____

Address (if different from patients) _____Phone (____)_____

City_____ State _____ Zip_____

Person Responsible Employed By_____ Business Phone (____)_____

Insurance Company _____

Contract # _____ Group# _____ Subscriber# _____

Names of other dependents covered under this plan_____

Dr. Alexandra George, DDS, LVIF - Health History Form

Date:	E-mail:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:

Last First Middle

Height: Weight: Date of birth: Sex: M F

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Dental Information *Please mark (X) to indicate your responses to the following questions.*

Have you experienced any of the following: YES NO

Bleeding gums when you brush or floss? _____

Tooth sensitivity to cold, hot, sweets or pressure? _____

Food or floss catching between your teeth? _____

Dry mouth? _____

Sores or ulcers in your mouth? _____

Serious injury to your head or mouth? _____

Do you:

Have earaches or neck pains? _____

Have any clicking, popping or discomfort in the jaw? _____

Brux or grind your teeth? _____

Get headaches frequently? _____

Wear dentures or partials? _____

Have you ever had any of the following: YES NO

Periodontal (gum) treatments? _____

Orthodontic (braces) treatment? _____

Problems associated with previous dental treatment? _____
If yes please explain

Are you currently experiencing dental pain or discomfort? _____
If yes please explain

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Where were they done?

What is the reason for your dental visit today?

Medical Information

Are you in good health? YES NO

Any change in your general health in the past year? YES NO
If yes please explain

Any serious illness or hospitalization in past 5 years? YES NO
If yes please explain

Date of last physical exam: _____

Who are your doctors?

Primary Care Provider _____

Other _____ Specialty _____

Other _____ Specialty _____

Other _____ Specialty _____

Other _____ Specialty _____

Are you taking any prescription medications? YES NO
Please list

Are you taking any over the counter medications? YES NO
Please list

Are you taking any supplements, vitamins or herbal preparations? YES NO
Please list

Medical Information (cont.) *Please mark (X) to indicate your responses to the following questions*

Are you allergic to or have you had a reaction to:

	YES	NO
Local anesthetics		
Aspirin		
Penicillin or other antibiotics		
Codeine or other narcotics		
Other Medications (specify)		
Metals		
Latex (rubber)		
Food (specify)		
Hay fever/seasonal		
Animals		
Other (specify)		

	YES	NO
Are you Pregnant?		
Do you use tobacco? (smoking, snuff, chew)		
Do you drink alcoholic beverages?		
If yes, how much do you typically drink in a week?		

Have you ever had any of the following:

	YES	NO
Artificial joint replacement? (finger, hip, knee, elbow)		
Artificial (prosthetic) heart valve?		
Infective carditis?		
Damaged valves in transplanted heart?		
Congenital heart disease?		

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? **YES** **NO**

Name of physician or dentist making that recommendation: _____

Please mark (X) to indicate whether you have or have had any of the following diseases or conditions

	YES	NO
Angina		
Arrhythmia		
Cardiovascular disease		
Chest pain on exertion		
Congenital heart defect		
Congestive heart failure		
Damaged heart valves		
Heart attack		
Heart murmur		
High blood pressure		
Low blood pressure		
Pacemaker		
Stroke		
Asthma		
Bronchitis/Emphysema		
Tuberculosis		
Diabetes Type I or Type II		
Arthritis Osteo or RA		
Autoimmune disease		
Chronic pain		
Chronic fatigue		
Osteoporosis		

	YES	NO
Abnormal bleeding		
Anemia		
AIDS or HIV infection		
Sexually transmitted disease		
Recurrent infections type of infxn _____		
Thyroid problems		
Glaucoma		
Other vision or hearing problem		
Eating disorder		
Malnutrition		
Gastrointestinal disease		
Ulcers / Colitis		
Hepatitis, jaundice or liver disease		
Kidney problems		
Excessive urination		
Cancer Type _____		
Chemotherapy?		
Radiation?		
Severe or rapid weight loss		

	YES	NO
Epilepsy		
Seizures		
Neurological disorders		
Depression		
Anxiety		
Other mental health condition specify _____		
Sinus Trouble		
Night Sweats		
Severe Headaches		
GE Reflux (heartburn)		
Tonsillitis		
Snoring		
Stop breathing when sleeping		
Overweight		
High blood pressure		
Daytime sleepiness		
Sleep Disorder specify _____		
Other _____		

Do you have any disease, condition, or problem not listed above that you think I should know about? **YES** **NO**
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments: _____

Office Financial Policy

Welcome to our practice and thank you for choosing us as your healthcare provider. We wish to advise you of our policies and procedures to prevent any misunderstandings regarding our services. Please read this carefully and if you have any questions, do not hesitate to ask a member of our staff.

1. Please present your current insurance card at every visit. This is your verification of the correct insurance and consent to them on your family's behalf.

2. According to your insurance plan (this is an agreement between you and the insurance company), you are responsible for any and all co-insurance, deductibles, and non-covered services.

3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a pre-authorization is required prior to a procedure and what services are covered. NOT ALL SERVICES PROVIDED BY OUR OFFICE ARE COVERED BY EVERY PLAN. ANY SERVICE NOT DETERMINED TO BE COVERED BY YOUR PLAN WILL BE YOUR RESPONSIBILITY. OUR PRACTICE CONCERN IS FOR YOU AND YOUR DENTAL HEALTH NOT YOUR DENTAL INSURANCE.

4. If we do not participate in your insurance plan or you do not have insurance, PAYMENT IN FULL IS EXPECTED FROM YOU AT THE TIME OF YOUR OFFICE VISIT.

5. We will file a claim to your insurance carrier for you. Any amounts that are denied or unpaid will be billed to you. Most insurance plans will not pay the provider, therefore you will be responsible for the fee at the time of the service and your insurance company will reimburse you. We cannot guarantee the amount of the reimbursement that you will receive.

6. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill. Any account balance outstanding greater than 60 days will be charged additional billing fees and subsequently forwarded to a collection agency.

7. A $25.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

8. Regarding financial situations of children of divorced parents; we understand divorce can be a difficult situation, but we cannot involve ourselves. Therefore the parent that accompanies the child to their appointment is responsible for payment.

9. Our appointment times are limited. We require a 48 hour notice for cancelled appointments. There will be a $75.00 fee for missed appointments that are cancelled without adequate notice.

10. Accepted forms for payment are cash, check, debit, Carecredit, MasterCard and Visa.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Head of Household/Patient: _____

Date: _____