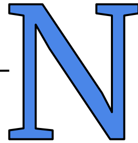


Nolt Dental Associates

1261 Division Hwy. Ephrata, PA 17517 717.738.1353 staff@noltdental.com

Health History Questionnaire

Your health history is very important to us. In order that we may procide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your teatment.

Last Name:	First Name:	MI:	DOB:
Address:		Phone #:	
Cell #:	Work:	Email:	
Dental Insurance:	Employer:		

Preferred Pharmacy:	Phone #:
Physician's Name:	Phone #:
Are you currently under the care of a physician? (circle one)	yes no
If yes, explain:	

Current Medications: Prescribed and Over-the-Counter (If NONE, please write none.)
1.
2.
3.

Have you ever had a serious illness, operation, or been hospitalized?			yes no
If yes, list year and explain:			
Have you ever had or been treated for: (circle all that apply. If NONE, circle none.)			
Blood Pressure: High or Low	AIDS/HIV	Heart Disease	Diabetes
Immuno-compromised Disease	Fibromyalgia	Hepatitis: A B C	Heart Valve
Dry Mouth	Asthma	Bleeding/Clotting Disorder	Artificial Joints
Heart Murmur	Tuberculosis	Stroke	Fainting
COPD	Transplant (kind):		None
Are you allergic to anything?	yes no		
If yes, please list:			

For Women:	Are you pregnant or do you think you may be pregnant? yes no
	Are you taking birth control pills? yes no

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient/Guardian Signature: ______________________________ Date: _____________________

Nolt Dental Associates, P.C.

1261 Division Hwy. Ephrata, PA 17522 717.738.1353 staff@noltdental.com

Nolt Dental Associates Financial Policy

We are committed to providing you with the best care possible. If you have dental insurance, we are pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment is due on the day of service. Nolt Dental Associates accept cash, checks, debit cards, and credit cards. As a courtesy, all services performed in our office will be submitted to your insurance carrier. We DO NOT participate with any insurance company; you will be responsible for any balance that your insurance company does not pay. A 1.5% per month finance charge will be added monthly to cover billing expenses. (18% Annually)

Initials: _____

Returned checks will be subject to an additional $50.00 collection fee. Charges may also be made for a **broken or missed** appointment.

Initials: _____

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer (possibly), and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

In **Workers' Compensation** cases, we will send appropriate claim forms for services rendered on your behalf. If and when a claim is denied we will expect payment from the patient within 30 days of receipt of our bill. If the patient has other insurance options, please submit the information at the time of service.

Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R" which is defined as usual, customary and reasonable by most companies. This statement does not apply to companies, who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area

We must emphasize that as dental providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are strictly your responsibility from the dates services are rendered.** Therefore, it is necessary for you to inquire and explore your benefits with your insurance carriers. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

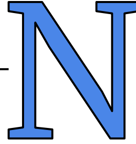
Initials: _____

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

In order for Nolt Dental Associates to provide the quality of care it offers, you must be willing to do your share in helping us to help you receive insurance benefits for which you are entitled.

______________________________ ______________________

Patient's Signature or Parent/Legal Guardian Signature Date



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Medical Release Form

In the event that dental results and/or treatments can not be given to the patient, I hereby authorize Nolt Dental Associates and its employees to leave dental results and/or treatment messages on my answering machine, or with the contact person/persons listed below. I further release Nolt Dental Associates, and its employees, from any liability for providing such required medical treatment pursuant to the authorization.

Initials: _____

Please list the names of those individual who is an emergency contact and that we may discuss your dental care and/or payment issues.

Name	Relation to Patient	Phone Number

I authorize the release of any of my x-rays and dental records to any doctor of my choosing to help in the treatment of my dental needs.

Initials: _____

Reminder Phone Calls

I understand that Nolt Dental Associates, and its employees may call and remind me about upcoming appointments. This will usually take place two days before my appointment. In the event that I cannot be reached, I authorize Nolt Dental Associates, and its employees, to leave a message on my answering machine. If I choose to **NOT** have reminder calls I am aware that I WILL be charged a fee for a broken or missed appointments,

Please remind me of appointments **Initials:** _____

Please **DO NOT** remind me of appointments **Initials:** _____

Signature: ______________________________ **Date:** ____________________