Fetterolf Dental Medicine
~ 3029 N. Front St. First Floor, Harrisburg, PA 17110 ~ (717) 233-7718 ~
~ 874 N. River Rd. Halifax, PA 17032 ~ (717) 896-2296 ~

Welcome To Our Practice!

Please provide us with the following confidential information.

Personal Information

Name: _____ Date: _____

Nickname or Name Preference: _____

Address: _____

City, State, Zip: _____

Phone: (____)_____ Business Phone: (____)_____

Cell Phone: (____)_____ E-Mail: _____

Social Security Number: _____-____-_____ Birthday: ____/____/____ Age: _____

Marital Status: _____ Spouse's Name: _____

If patient is a **minor or full-time student**, please complete the following:

Parent/Guardian Name: _____ Phone: (____)_____

Address: _____

Emergency Contact

In case of an emergency, whom may we contact?

Name:_____ Relationship: _____

Phone Number(s): _____

Referral Information

Who may we thank for referring you to our practice? _____

Employer Information

Employer Name: _____

Occupation _____ How Long: _____

Form Continues on Back

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Insurance

Do you have dental insurance? **YES** **NO**

Insurance Company:_____ Group Number:_____

Under whose name is the insurance listed (employee)? _____

Insured's Social Security Number: _____-_____-_____ Insured's Birth Date: ____/____/____

Employer: _____

Are you covered by a secondary dental plan? **YES** **NO**

Insurance Company:_____ Group Number:_____

Under whose name is the insurance listed (employee)? _____

Insured's Social Security Number: _____-_____-_____ Insured's Birth Date: ____/____/____

Employer: _____

Office Policies & Authorization and Release

Broken Appointment and Cancellation Policy

Your appointment has been reserved for you. A 24-hour notice is required to cancel or reschedule an appointment. A minimum of $55.00 will be charged to your account for each appointment that is broken, cancelled or rescheduled without the required notice.

Financial Policy

Payment is expected at the time of service unless other arrangements have been made. We accept cash, check, Visa, Master Card, American Express and Discover. If you would like our office to bill your credit card at the end of the month for any remaining balance, please fill out our "Pre-Authorized Healthcare Form." Account balances older than 90 days are subject to finance charges unless an active payment plan is in place.

Authorization and Release

I certify that the above information has been accurately provided. I authorize the dentist(s) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request that my insurance company, should I have dental insurance and if they will do so, to pay any insurance benefits directly to the treating dentist. I understand that if I have dental insurance and the carrier pays less than the actual fee for services that I am responsible for those fees. I agree to be responsible for the payment of all services rendered on my behalf or my dependents, and also for any charges that arise for the collection of those fees.

I have read, understood and agree to the above policies:

_____

Signature of patient or parent/guardian if patient is a minor