Langhorne Family Smiles
712 A Trenton Road
Langhorne Pa 19047

Patient Registration Forms

Personal Information

Name (Last, First) _____

Preferred Name _____

Address _____

_____

Email _____

Cell Phone _____ Home Phone _____

Birth Date_____ Age _____ Marital Status_____

Sex _____ SS Number _____

Person Responsible/Guarantor

Name _____

Date Of Birth _____ Phone _____

Address _____

_____

Primary Dental Insurance

Insurance Name _____

ID Number _____

Group Number _____

Policy Holder Name _____

Relation to Patient _____

Policy Holder Address _____

_____

Policy Holder SS Number _____

Medical Information

Any Known Allergies

_____

_____

Please List All Medications You Currently Take

_____

_____

Anorexia	**Y N**	**Auto Immune Disease**	**Y N**
Asthma	**Y N**	**Arthritis**	**Y N**
Bladder Trouble	**Y N**	**Blood Clotting**	**Y N**
Blood Transfusion	**Y N**	**Bulimia**	**Y N**
Bronchitis	**Y N**	**Cancer/Tumor**	**Y N**
Cardiac Pacemaker	**Y N**	**Cardiovascular Disease**	**Y N**
Chemotherapy	**Y N**	**Chest Pain**	**Y N**
Color Blindness	**Y N**	**Fainting Spells**	**Y N**
Fever Blisters	**Y N**	**Frequent Headaches**	**Y N**
Frequent Dry Mouth	**Y N**	**Gag Reflex**	**Y N**
Gall Bladder Trouble	**Y N**	**Hay Fever**	**Y N**
Heart Attack	**Y N**	**Heart Disease**	**Y N**
Heart Murmur	**Y N**	**Hepatitis**	**Y N**
Herpes	**Y N**	**High BP**	**Y N**
Hives	**Y N**	**Jaundice**	**Y N**
Joint Replacement	**Y N**	**Kidney Trouble**	**Y N**
Pre Medicate	**Y N**	**Radiation Treatment**	**Y N**
Rheumatoid Arthritis	**Y N**	**Seizures**	**Y N**
STD	**Y N**	**Skin Rash**	**Y N**
Shortness Of Breath	**Y N**	**Sinus Trouble**	**Y N**
Stomach Ulcers	**Y N**	**Stroke**	**Y N**
Thyroid Problems	**Y N**	**Tuberculosis**	**Y N**
Abnormal Bleeding	**Y N**	**Aids/HIV**	**Y N**
Alcohol/Duug Abuse	**Y N**	**Anemia**	**Y N**
Congenital Heart Defect	**Y N**	**Contact Lenses**	**Y N**
Damaged Heart Valve	**Y N**	**Diabetes**	**Y N**
Emphysema	**Y N**	**Epilepsy**	**Y N**
Leukemia	**Y N**	**Liver Disease**	**Y N**

Low BP	**Y N**	**Lupus**	**Y N**
Mental Health Problems	**Y N**	**Mitral Valve Prolapse**	**Y N**

Any other Health Concerns NotListed Above

_____

Women Only

Any Chance of Pregnancy Y N
If Yes, What Is The Due Date _____
Are you Nursing Y N
Do You Have Menstrual Problems Y N
Are You On Hormone Replacement Therapy Y N
Are You On Birth Control/Fertility Drugs Y N

Dental Questions

Previous Dentist _____

Phone Number _____

Last Exam _____

Last Xrays_____

Are Teeth Sensitive to Hot or Cold Y N
Do You Get Frequent Fever Blisters Y N
Have You Had Burning Of The Tongue Y N
Do You Smoke/Chew Tobacco Y N
Have You Had Any Neck Or Jaw Injuries Y N
Do You Have Clicking or Soreness Of Jaw Y N
Do You Clench Or Grind Teeth Y N
Have You Ever Had Orthodontic Treatment Y N
If Yes, Date _____
Do You Wear Dentures or Partials Y N
Are You Happy With Your Dentures Y N
Are You Having Any Specific Problems At this Time With Your Teeth, Gums, Or Mouth_____

_____

Are You Happy With Your Smile Y N

Do You Have Problems With Teeth Or Filling Breaking Y N

Do You Regularly Use Dental Floss **Y N**

Have You Ever Been Told That You Have Periodontal Disease **Y N**

Do You Have Any Unpleasant Taste or Odor In Your Mouth **Y N**

Does Food Catch Between Your Teeth **Y N**

Do You Want To Learn To Control Dental Disease **Y N**

Medical Questionnaire

Emergency Contact _____

Phone Number _____

Medical Insurance Carrier_____

Medical Insurance Carrier Employer _____

Subscriber Name _____

Subscriber ID Number _____

Family Physician_____

Phone _____

Are You Currently Under The Care Of A Physician **Y N**

If yes For What Condition _____

Have You Taken Bisphosphonates (Fosomax, Boniva, etc) **Y N**

Have You Even Taken The Diet Control Drug Fen-Phen **Y N**

By Signing Below I certify That All The Above Information Is True To The Best Of My Knowledge

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Dentist Signature **Date**

HIPAA Compliance Patient 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. 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 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 dental conditions with any member of your family?	YES	NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

March 18, 2024

Dear Dental Patients,

In order to continue providing quality services and maintain the financial viability of our dental program, patients are responsible for the following: Pay their remaining balances in full prior to receiving further non-emergent care. If your existing balance is not paid in full, we will not be able to continue elective care and you will be rescheduled. Payment is due in full at the time of your visit. For all major dental work (dentures, crowns, bridges, ect), 50% of the fee will be required before the first appointment can be scheduled. The remaining 50% balance must be paid at the time the appliance is delivered. Patients will be alerted when payments are due so that they can bring the proper funds to the dental visit. No major work will be started until a 50% deposit toward services is made, and no delivery of the final product will be made until the balances are paid in full. No one with a dental emergency will be denied services, regardless of their ability to pay; however, elective/follow-up work relevant to the emergency visit will not be started until all outstanding balances are paid.

Unfortunately, due to recent events, Langhorne Family Smiles will now be charging a cancellation fee of $25 for all appointments canceled or missed without 48 hours notice. We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or canceling an appointment with less than 48 hours notice means we are unable to fill this appointment time with another patient who desperately needs care.

As a Practice, we do understand that things happen that are unexpected and emergent. These events will be looked at on a case by case basis to deem if the missed or cancellation fee is relevant. Patients are only allowed two missed appointments. After the second missed appointment, you will be placed on “same day” only status.

If there are any questions about our new office policy, feel free to consult Dr. Thorat or the office manager for further explanation. We thank you for your continued understanding.

Signature Date