Date____

Print Name ____

Louis L. Trovato, DDS, FAGD, FICOI
Fellow of the Academy of General Dentistry
Wendy M. Beratan, DMD
www.meetinghousedental.com
215-293-0909

Welcome to Our Practice!

We are complimented that you have selected us to provide your dental care.

Whom may we thank for referring you to our office?____

Guest Information

Completed guest information will allow us to ensure your safety in case of emergency, to process your insurance claims as a courtesy to you, to alert you to unexpected schedule openings, and to correspond regarding dental matters. Thank you!

Guest's Last Name________________________________ First Name__________________________

Middle ____________ Title________ Preferred Name____________________ Marital Status_______

Social Security _________-_________-______________ Birth Date_______/_______/__________

Street Address____

City____ State__________ Zip Code____________

Home Phone _________-_________-___________ Cell Phone _________-_________-___________

Pager ______-______-__________ E-Mail ____

Occupation ____________________________ Employer __________________________________

Employment Address ____

Work Phone ________-________-____________

Emergency Contact _________________________________ Phone ________-________-__________

Relationship to Guest________________________________ Phone ________-________-__________

For Full-Time College/University Students: School____

Phone at School ________-________-___________

E-Mail at School____

Responsible Party Information if Different From Above

Last Name ____ First Name ____

Middle ________________________ Relationship to Patient ____

Social Security _____________-_____________-________________ Birth Date __________/__________/______________
_

Street Address ____

City ____ State______________ Zip Code _______________________

Home Phone ________-_________-____________

Occupation ____________________________________ Employer ____

Employment Address ____

Work Phone ___________-___________-________________

Insurance Information

Insured's Last Name_______________________________________ First Name_________________________________

Middle _______ Is insured a patient? Yes No Insured's Relationship to Guest _______________________

Insured's Social Security #_________-_________-____________ Insured's Birth Date ________________________

Insurance Company ____ Group Number __________________________

Insurance Company Address ____

Insurance Company Phone _______-________-__________ Insured's Employer______________________________

Employment Address____ Work Phone ________-________-__________

If you have dual coverage, please complete the following secondary insurance information.

Insured's Last Name_______________________________________ First Name__________________________________

Middle _______ Is insured a patient? Yes No Insured's Relationship to Guest ___________________________

Insured's Social Security #_________-_________-____________ Insured's Birth Date __________________________

Insurance Company ____ Group Number _________________________

Insurance Company Address ____

Insurance Company Phone _______-________-__________ Insured's Employer_________________________________

Employment Address____ Work Phone ________-________-__________

Print Name____

Medical Information

Have you been a patient in the hospital during the past two years? Yes No

Have you been under the care of a medical doctor during the past two years for a specific condition? Yes No

Date of most recent medical exam: ____

Physician's Name__________________________ Physician's Address ____________________

__________________________ Physician's Phone ________-________-________

Please list any medication or drugs you are taking, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins minerals, etc. ______________________________

____

Please list any medication or anesthetics to which you are allergic. ______________________________

Do you need to pre-medicate prior to dental treatment? Yes No

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Heart Disease or Attack	Yes	No	Hay Fever	Yes	No	Involvement in Accident	Yes	No
Angina Pectoris	Yes	No	Respiratory Problems	Yes	No	Whiplash Injury	Yes	No
Congenital Heart Disease	Yes	No	Allergies	Yes	No	Severe Blow to Head	Yes	No
Heart Murmur	Yes	No	Latex Allergy	Yes	No	Severe Blow to Jaw	Yes	No
High Blood Pressure	Yes	No	Codeine Allergy	Yes	No	Chronic Back Pain	Yes	No
Arteriosclerosis	Yes	No	Penicillin Allergy	Yes	No	Chronic Shoulder Pain	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatitis A (infectious)	Yes	No	Chronic Neck Pain	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis B (serum)	Yes	No	Stiff Neck Muscles	Yes	No
Heart Pacemaker	Yes	No	Hepatitis C	Yes	No	Tension Headaches	Yes	No
Heart Surgery	Yes	No	Venereal Disease	Yes	No	Migraine Headaches	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No	Headaches Back of Head	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No	Headaches Temple Area	Yes	No
Anemia	Yes	No	Hemophilia	Yes	No	Chronic Facial Pain	Yes	No
Arthritis	Yes	No	Sickle Cell Disease	Yes	No	Pain in Jaw Joint	Yes	No
Rheumatism	Yes	No	Hives	Yes	No	Clicking, Popping Jaw	Yes	No
Cortisone Medication	Yes	No	Easy Bruising	Yes	No	Locking Jaw	Yes	No
Artificial Joints (hip, etc.)	Yes	No	Yellow Jaundice	Yes	No	Tired Jaw After Sleep	Yes	No
Liver Disease	Yes	No	Epilepsy or Seizures	Yes	No	Tired Jaw After Meal	Yes	No
Kidney Trouble	Yes	No	Nervousness	Yes	No	Foods You Avoid	Yes	No
Diabetes	Yes	No	Anorexia/Bulimia	Yes	No	Aching Jaw Opening Wide	Yes	No
Ulcers	Yes	No	Wisdom Tooth Extraction	Yes	No	Difficulty Opening Wide	Yes	No
Thyroid Problems	Yes	No	Bleeding Gums Brushing Teeth	Y	N	Trouble Sleeping	Yes	No
Glaucoma	Yes	No	....			Cracking In Jaw Joint	Yes	No
Cancer	Yes	No	Family History of Jaw Problems	Y	N	Teeth Clenching	Yes	No
Radiation Therapy	Yes	No	Ear Pain	Yes	No	Teeth Grinding at Night	Yes	No
Chemotherapy	Yes	No	Itchiness in Ear	Yes	No	Sore Teeth After Sleep	Yes	No
Emphysema	Yes	No	Stuffiness in Ear	Yes	No	Blurred Eyesight	Yes	No
Chronic Cough	Yes	No	Ringing/Buzzing in Ear	Yes	No	Snoring	Yes	No
Tuberculosis	Yes	No	Hissing/Grating in Ear	Yes	No	Chronic Stuffed Nose	Yes	No
Tumors	Yes	No	Loss of Hearing	Yes	No	Recurring Nausea	Yes	No
Asthma	Yes	No	Pain In/Around/Behind Ear	Yes	No			

Print Name____

Do you have or have you had any disease, condition or problem not listed on the previous page? Yes No

If yes, please identify ____

Did you take the diet drug Fen-Phen that is no longer on the market? (You may need to pre-medicate.) Yes No

Do you have any disease, are you taking any medication/drugs, or have you had any transplant operation that has or may have depressed your immune system? Yes No

Do you have a history of alcohol or chemical dependency or of an emotional disorder or of any developmental disability that may have an impact on your needs or on the care we provide you? Yes No

Do you wish to speak with the doctor privately about anything? Yes No

For Women: Are you pregnant? Yes No Due date______________
Are you nursing? Yes No Are you taking birth control pills?* Yes No

* If you are using non-mechanical contraceptives, antibiotics *may* interfere with their effectiveness. Consult your physician; you may wish to use mechanical forms of birth control for one full cycle after completion of antibiotic treatment.

If you experience headaches, please complete the following questions.

If you take medication for pain relief, what do you take? ________________________________ N/A

How often do you take it? ____ N/A

When are your symptoms the worse? ____ N/A

Does anything make you feel better? ____ N/A

If you have been involved in a serious accident, will you provide details?_________________________

____ N/A

When you experience headaches, do you also experience the following? ______ Fatigue

______ Nausea ______ Light Sensitivity ______ Noise Sensitivity ______ Blurred Vision ______ Dizziness

Please indicate the location and type of pain. Key: L = Left R = Right B = Both Sides

				Severity		/	Frequency		/	Duration			
			Location	**Mild**	**Moderate**	**Severe**	**Occasional**	**Frequent**	**Constant**	**Seconds**	**Minutes**	**Hours**	**Days**	**Weeks**
L	R	B	Front of your head											
L	R	B	Entire head											
L	R	B	Back of your head											
L	R	B	In your temples											

Do you fear dental work? Yes No

Ideally, is there anything you wish to change about the appearance of your smile (discolored, crooked, crowded teeth or fillings, gaps, missing teeth, too small or too large teeth, gummy smile, etc.)? (To learn more about smile options, you can also visit us on-line at www.meeetinghousedental.com!)

____

____

Print Name ____

Children Under Age 10

Dear Parents:

Please indicate conditions that pertain to your child so the doctors will know if he or she might be a candidate for functional jaw orthopedic intervention.

For some children, early intervention can minimize or even eliminate the need for orthodontic care in the teenage years. Functional jaw orthopedics develop healthy jaw joints, an aesthetic profile, and a broad smile, and it addresses restricted arches, palate and jaw malformations, cross bite, open bite, crowded and/or overlapping teeth, and compromised airways.

For more information, you can also visit us on-line at www.meetinghousedental.com!

	YES	NO
Thumb or finger sucking beyond 1 year of age	( )	( )
Tongue thrust habit through opening in front teeth	( )	( )
Tendency to breathe through the mouth	( )	( )
Shortness of breath	( )	( )
Allergies	( )	( )
Ear infections	( )	( )
Tubes in ears	( )	( )
Hearing disorders	( )	( )
Dizziness	( )	( )
Migraines or repetitive headaches	( )	( )
Head or face injury	( )	( )
Sore throats	( )	( )
Tonsillitis	( )	( )
Inflamed adenoids	( )	( )
Poor posture	( )	( )
Sleep problems	( )	( )
Sore teeth or jaws upon awakening	( )	( )
Diagnosed ADD and ADHD	( )	( )
Speech problems	( )	( )

Consent:

1. I understand that the above information is necessary for the doctors to provide me with comprehensive dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.
2. I authorize the doctors of Meetinghouse Dental Care to take radiographs and photographs, make study models, or employ other diagnostic aids deemed appropriate by them for the purpose of making a thorough diagnosis of my dental needs.
3. I authorize the doctors of Meetinghouse Dental Care to perform all recommended treatment with which I have agreed and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
4. I authorize the release of examination findings, diagnosis, treatment program, etc., to my referring or treating dental specialists and/or physicians.
5. I understand that all responsibility for payment for dental services provided in this office for myself and/or for my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
6. If I have dental insurance, I realize that my insurance coverage represents a contract between my insurance company and me and that said coverage depends upon the plan that I have chosen or that the insured's place of employment has purchased on my behalf. I am aware that some procedures I may require may not be a benefit of my particular plan. I also understand that Meetinghouse Dental Care submits my claims to my insurance carrier purely as a courtesy to me. Should insurance payment be denied or should reimbursement be less than the estimated amount, I am responsible for the treatment fee in full.
7. If I have dental insurance, I realize that I am responsible for maintaining contact with my insurance carrier through the phone number on my insurance card in order to monitor reimbursement paid throughout the contract year relative to the maximum coverage allowed. Should the maximum benefit coverage be exceeded in a given contract year, I am responsible for the balance that remains.
8. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
9. If I am 18 years of age or older and if my parents/guardians are my guarantors, I give permission for Meetinghouse Dental Care to submit dental claims on my behalf to the insurance company to which my parents/guardians subscribe. I give permission for Meetinghouse Dental Care to place a phone call to my parents'/guardians' home regarding those claims, account balances, and/or account credits and/or to mail statements or other information to my parents'/guardians' home address regarding those claims, account balances, and/or account credits.

Guest Signature____ Date ______________

OR

Signature of Parent or Responsible Party ____

Relationship to Guest _______________________________________ Date ______________

Provided that my name is not revealed, I authorize the doctors of Meetinghouse Dental Care to use study models, radiographs, photographs of my mouth, etc. in lectures or seminars which the doctors conduct, in articles or columns which the doctors author, or in before/after displays that the practice mounts.

Guest Signature____ Date ______________

Meetinghouse DENTAL CARE Personalized & Comfortable
215-293-0909

This page is for you to retain. We invite you to read it and to ask for clarification if you have questions! At Meetinghouse Dental Care, we believe in discussing your oral health needs, the investment involved, and our Guest Financial Agreement prior to service. Realizing that each person's situation is different, we offer several options to ensure that you receive the dental care needed to enjoy a healthy and confident smile.

Payment Options

- We accept cash, personal check, Visa and Mastercard credit and debit cards, and Discover and American Express credit cards.
- For guests who prefer an extended monthly payment plan, we can help! We have chosen two excellent healthcare financing companies - Healthcare Creditline and Dental Fee Plan - to meet your needs. There is no application fee or down payment required. The paperwork is minimal, and approval is decided as you wait (3-15 minutes). We can help you choose which healthcare financing company might best provide you with terms to match your budget comfortably. If you like, you can apply today in the office - or at home through our website: www.meetinghousedental.com! *No prepayment savings apply for this option.*
- We extend a 10% courtesy to all non-insured senior citizens (65 years of age and older) AND to all insured* senior citizens who choose to pay the practice directly and to accept private assignments of benefits. *Not to be combined with other offers. Not valid toward products.*
- We offer our uninsured guests a 5% pre-payment accounting courtesy on their investment paid in full by cash or check prior to the start of treatment for treatment plans of $1000 and above.
- We offer our insured* guests the option of realizing the same 5% pre-payment savings on a ***total treatment plan*** of $1000 and above by paying the practice in full by cash or check prior to the start of treatment and accepting private assignments of insurance benefits.
- We offer insured* guests a 5% prepayment savings on an ***estimated private payment portion*** of $1000 and above by paying the practice in full by cash or check prior to the start of treatment.
- For procedures requiring 2 or 3 visits (i.e. crowns, partials, appliances, etc.), we accept two or three equal payments. The first payment is due at the beginning of treatment; the second payment is due at the second visit, etc. *No prepayment savings apply for this option.*
- Invest as you go. We will prioritize our treatment recommendations for you, and you can complete any non-urgent, elective dental work by spreading your appointments over several months or even years.

* Offer excludes guests with Delta Dental Insurance for which we are in-network providers.

(Over for Dental Insurance)

Dental Insurance:

If you have dental insurance, we will help you to maximize the benefits to which you are entitled. We will also be pleased to estimate your coverage and to process your claims as a courtesy to you. Many variables exist from carrier to carrier, however (deductibles, annual maximums, allowable fee limitations, non-covered procedures, Usual and Customary Fee Schedules, etc.), and we cannot guarantee private payment portion estimates as anything other than what they are: estimates. Dental insurance plans are intended to support your investment in your dental health rather than to cover all procedures completely, and the degree of your coverage will always depend upon the particular contract that you and/or your employer have chosen. Ultimately you are responsible for charges incurred. If your insurance carrier has not paid its portion within 30 days from the start of treatment, we may contact you to request that you call the company. Often your call will speed the consulting process and the approval of compensation. If your insurance company has not paid its estimated portion within 90 days from the start of treatment, we will let you know; you will become responsible for payment to this office at that time. We will continue to support your unpaid claim by satisfying any additional requests from your insurance company, and subsequent reimbursement from your carrier will be made directly to you.

We'll be glad to clarify any aspect of your treatment or financial obligations/ arrangements. Don't hesitate to ask for more information!

As always, we value the privilege of serving you.

The Meetinghouse Dental Care Team

Louis L. Trovato, DDS, FAGD, FICOI
Wendy M. Beratan, DMD
865 West County Line Road, Hatboro, PA 19040
215-293-0909
www.meetinghousedental.com

Guarantee

Since 1983

We are often asked, "How long will this crown – or porcelain veneer – or etc. – last?" So many factors influence the longevity of dental restorations that our best estimates can never be more than estimates. We **do**, however, fully support your investment in optimal dental health, and we **love** to exceed your expectations. It is, therefore, our pleasure to continue to offer you what we believe to be a *unique* value in dentistry . . .

Our Part

If the following restorations are found to need replacement within the time period indicated, if the tooth beneath is salvageable, if Dr. Trovato and Dr. Beratan maintain their private practice in dentistry, and if you have done your part (see below), we will, *at no charge*:

- Replace any crown with a new crown of the same type for up to 5 years
- Replace any veneer or onlay with a new veneer or onlay of the same type for up to 5 years
  - If the tooth on which we have placed a veneer or onlay is damaged or decayed to the extent that a crown is necessary, the full fee originally paid for the veneer or onlay will be applied toward the crown fee. You pay only the difference.
- Replace or repair any composite restoration with composite restoration for up to 2 years
  - The ideal filling is no more than 50% of the tooth. If more than 50% of the tooth has been compromised, a crown build-up and crown will be indicated. If indicated, we will credit the full fee originally paid for the composite restoration toward the new crown build-up and crown. You pay only the difference.
- Replace any bridge, partial, or denture with a new bridge, partial or denture of the same type for up to 5 years

Note: We cannot predict if gum or root canal treatment will ever be needed. If needed, these procedures will incur a separate fee.

Your Part

. . . because achieving and maintaining optimal dental health requires a partnership between providers and guest!

- Visit our office a minimum of 2 times per calendar year - - 3 or 4 if we've diagnosed a gum condition - - for exams and professional cleanings
  - Many of our guests remain with the practice even after moving away. If you move out of the area, one exam and professional cleaning in our office annually will maintain this guarantee.
- Carry no outstanding balance over 30 days on any dental work after insurance claims are paid