Silver Dental

Dr. Scott Silver, DMD
621 White Horse Pike, Haddon Township, NJ 08107
856-854-4354

Dr. Bruce Silver, DMD
1816 Mount Holly Road, Burlington, NJ 08016
609-387-1844

The Financial Aspect of Your Dental Treatment

Our primary goal is to provide patients with the highest quality dentistry available, using the latest techniques and materials to ensure long lasting, beautiful results. We realize that this needs to be accomplished while keeping your budget in mind. All costs for your dental care will be discussed in detail so you may plan and budget for your treatment.

INSURANCE--For those of you that have dental insurance, we will bill your carrier as a COURTESY TO YOU, with you paying the estimated copay at the time of service. We will assist in claims submissions to obtain payment for your treatment. However, in some instances your insurance company will only send payment directly to you. If that is the case, we ask that you pay in full for your treatment at the time it is performed, and we will be glad to submit the paperwork to your insurance carrier for your direct reimbursement.

We will attempt to estimate how your insurance company will pay for your dental services, but we have no way of knowing exactly what they will pay until the claim is ultimately paid. There is no way we can guarantee what your insurance will pay. Please be advised-when your carrier is to pay us directly and if that payment is not received within 90 days of our submitting the claim, that dollar amount will automatically become your responsibility. This amount will be billed to you and is due upon receipt of a statement.

APPOINTMENTS--We will make every effort to schedule your appointment at a time that is convenient for you. Appointment times are customized according to your needs. When you make your appointment, please keep in mind that we are reserving that time especially for you. We respect your valuable time and we ask the same consideration from our patients. Cancellations less than 24 business hours prior to your appointment could result in a charge according to the length of your missed appointment.

PAYMENT OPTIONS

A. Payment in full at initial visit by check or cash.
B. Payment in full at initial visit by credit card
C. No interest or installment payment arrangements through an outside financial source. Our staff will provide you with information to utilize this fast and simple way for payment of dental treatment.

AUTHORIZATION

I understand that I am responsible for all cost of dental treatment and authorize payment of dental benefits directly to this office. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I have provided to this office on this form and any other completed and signed by me is correct to the best of my knowledge. I will not hold Dr. Bruce Silver or Dr. Scott Silver or any member of their staff responsible for any errors or omissions that I may have made in the completion of my medical or insurance information.

FINANCE CHARGE

If I do not pay the entire new balance of my account within 60 days of the billing date, a Finance Charge of 2% will be added to the account for each monthly billing period. In the case of default of payment I promise to pay any legal interest on the balance due, along with any collection costs and reasonable attorney fees incurred to effect collection of this account.

I understand and agree to the above____Date_________

(Patient/Parent/Guardian)

WELCOME

TO THE OFFICE OF SILVER DENTAL

PATIENT INFORMATION

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Today's Date_____________________ **E-Mail Address**_______________________

Name____**Birthdate**_________________

First MI Last

Address____

Social Security #_____________________**Telephone # (H)**___________________**(W)**_______________________

Do you prefer to receive calls at: Home ( ) Work ( ) Either ( )

Are you: Male ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( )

You or your parent's employer_______________________________________**Occupation**___________________

Business Address____

Spouse's or Parent's name_______________________________________**Work Phone #**_____________________

If you are a student, name of school_______________________________**Address**__________________________

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

Person to contact in an emergency_______________________________________**Phone**_____________________

RESPONSIBLE PARTY

Name of person responsible for this account__________________________________**SS#**___________________

Relationship to patient_________________________________**Home Phone #**______________________________

Address____

Name of employer___________________________________**Work Phone #**________________________________

INSURANCE INFORMATION

Name of insured_____________________________________**Relationship to patient**__________________________

Name of employer_________________________________**Work Phone #**___________________________________

Birthdate_________________________________**Social Security #**____

Insurance Company______________________________________**Group #**___________________________________

INSURANCE: We will bill your insurance company as a COURTESY TO YOU. We will assist in all necessary claims submissions in order to obtain payment for your dental services. You are expected to pay your portion of treatment at the time of service. Your insurance carrier's financial responsibility and your co-payment is only an estimate. Anything not covered by your insurance company will be billed to you and payable upon receipt. Remember the ultimate responsibility for payment is yours.

CONFIDENTIAL

DENTAL HISTORY

Reason for today's visit____

Former Dentist____**Date of Last Visit**__________________________

How often do you brush?______________________________**How often do you floss?**_________________________

Please check any of the following conditions that apply to you:

( ) Bad breath	( ) Grinding teeth	( ) Sensitivity to hot
( ) Bleeding gums	( ) Loose teeth or broken fillings	( ) Sensitivity to sweets
( ) Clicking or popping of jaw	( ) Periodontal treatment	( ) Sensitivity when biting
( ) Food collects between teeth	( ) Sensitivity to cold	( ) Sores or growths in mouth

MEDICAL HISTORY

Physician_____________________________________**Phone #**____________________**Last visit**_________________

Please list all medications you are currently taking ____

____

Are you allergic to any of the following:

Aspirin NO ( ) YES ( )	Acrylic NO ( ) YES ( )	Penicillin NO ( ) YES ( )
Latex NO ( ) YES ( )	Codeine NO ( ) YES ( )	OTHER:

<u>Women:</u> Are you pregnant? NO ( ) YES ( ) Nursing? NO ( )YES ( ) On birth control pills? NO ( ) YES ( )

Do you have a history of the following?

( ) Anemia	( ) Cough, Persistent	( ) Hepatitis	( ) Rheumatic Fever
( ) Arthritis, Rheumatism	( ) Diabetes	( ) High Blood Pressure	( ) Scarlet Fever
( ) Artificial Heart Valves	( ) Epilepsy	( ) HIV/AIDS	( ) Shortness of Breath
( ) Artificial Joints	( ) Fainting	( ) Jaw Pain	( ) Skin Rash
( ) Asthma	( ) Glaucoma	( ) Kidney Disease	( ) Stroke
( ) Back Problems	( ) Headaches	( ) Liver Disease	( ) Swelling Feet/Ankles
( ) Blood Disease	( ) Heart Problems	( ) Mitral Valve Prolapse	( ) Thyroid Problems
( ) Cancer	Describe____________	( ) Pacemaker	( ) Tobacco Habit
( ) Chemical Dependency	____________________	( ) Psychiatric Care	( ) Tuberculosis
( ) Chemotherapy	____________________	( ) Radiation Treatment	( ) Ulcer
( ) Circulatory Problems	( ) Hemophilia	( ) Respiratory Disease	( ) Venereal Disease

OTHER:____

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<u>FINANCE CHARGE</u>

If I do not pay the entire new balance of my account within 60 days of the billing date, a Finance Charge of 1.5% will be added to the account for each monthly billing period. In the case of default of payment I promise to pay any legal interest on the balance due, along with any collection costs and reasonable attorney fees incurred to effect collection of this account.

SIGNATURE (Patient/Parent/Guardian)____**Date**______________

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Smile Survey

Our office is conducting a survey of our patients. If you would kindly answer a few questions below, it would be greatly appreciated. ☺

How do you feel about your smile?

____
____
____
____

If you could change anything about your smile, what would it be? (If you had a magic wand!)

____
____
____
____

Is there anything that would keep you from improving your smile? If so, please explain.

____
____
____
____

Are you familiar with how today's dentistry can enhance your smile? **Yes / No**

Would you like to learn more about how you can improve your smile? **Yes / No**

Your name:_______________________________________

Thank You! ☺

E-mail: info@silverdental.com Website: www.silverdental.com