ELDERDENT PATIENT HISTORY – Please print & complete both sides of form.

Phone: 267-708-0156 Fax: 267-708-0158 Toll Free: 1-800-894-6655

Name of Facility_____Patient Phone #_____
Patient Name_____M__F__ Married__Widowed__
Address_____City_____State_____ Zip_____
Date of Birth_____Patient E-mail(if any):_____

Responsible Party (Person responsible for this account & appointments)_____
Address_____City_____
State_____ Zip_____Phone (H)_____(W)_____
Relationship to Patient_____

Patient's Dental Insurance THIS IS NOT MEDICAL INSURANCE OR MEDICARE
Name, Address & Phone # of Carrier_____
Name of Insured_____ SS#_____DOB_____
Group Company Name_____Plan #_____ID#_____

Patient Medical History
Physician Name and Phone #_____
Is PatientAmbulatory_____UsesWalker_____WheelChair_____

1. Is patient currently under medical treatment_____
2. Briefly describe current health condition_____
3. Do you wear: Upper Denture___ Lower Denture___Upper Partial__Lower Partial___ None____
4. Please list medications currently taken_____
5. Do you smoke Y N Use controlled substances Y N Approximate Weight _____
6. Are you allergic to any of the following:

Local Anesthetics(e.g. Novocain)_____	Iodine_____
Penicillin or Antibiotics_____	Aspirin_____
Sulfa Drugs_____	Any Metals (e.g. nickel, mercury)_____
Barbiturates_____	Latex Rubber_____
Sedatives_____	Other(please list)_____

6. Do you have or have you had any of the following **(Please circle correct choice)**

High Blood Pressure	Y N	Heart Disease	Y N	Low Blood Pressure	Y N
Cardiac Pacemaker	Y N	Liver Disease	Y N	Radiation Therapy	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Hepatitis	Y N
Kidney Disease	Y N	Cancer	Y N	Mitral Valve Prolapse	Y N
Dementia	Y N	Angina	Y N	Aids or HIV	Y N
Tuberculosis	Y N	Asthma	Y N	Epilepsy/Seizures	Y N
Anemia	Y N	Stroke	Y N	Thyroid Problems	Y N
Emphysema	Y N	Glaucoma	Y N	Respiratory Problems	Y N
Leukemia	Y N	Diabetes	Y N		

Other_____ Joint Replacement (Year)_____

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to ElderDent, LLC, insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand that providing incorrect information can be dangerous to my health.

X **Date**

Signature of Responsible Party **(OVER)**

CONSENT TO PROVIDE DENTAL TREATMENT

THIS AGREEMENT is made as of the date below, by the Resident and Responsible Parties identified below for the benefit of ELDERDENT, LLC., a Pennsylvania corporation ("ElderDent").

In consideration of the concerns expressed below, the Resident and the Responsible Parties agree with ElderDent and are legally bound as follows:

1. Consent to Dental Services. The Resident and the Responsible Parties (collectively, the "Undersigned") hereby consent to the supplying of dental services to the Resident by ElderDent, its employees and contractors. Undersigned acknowledges that their care and service will be provided by licensed dentists, dental assistants and dental hygienists (collectively, the "Dental Care Providers").
2. Dental Services to Be Provided. The Undersigned acknowledge and agree that the dental services to be provided to the Resident may include, when determined by the Dental Care Providers to be appropriate, regular oral exams, diagnostic x-rays, prophylactic and preventative procedures, restorative, prosthetic, crown and bridge work, periodontal treatments and endodontic care. In the event the Resident shall require care that exceeds preventative, diagnostic and restorative procedures, the Resident will be given a written estimate ("Estimate") of the projected treatment costs, which will include a description of the care to be provided and a list of alternative treatment options, if any.

   The cost of dental services provided in each Estimate shall be fixed for ninety (90) days. If treatment is not begun within that time period, the cost of the dental services may vary. Further, once dental treatment has begun, changes in the treatment plan may be required, depending upon oral conditions encountered. In such event, the Resident will be so advised, and will be given the option of continuing treatment, changing treatment or canceling treatment.

   For dental services not requiring an Estimate, the cost of dental services provided to the Resident shall equal the cost for each service as is identified on the then-current statement of fees of ElderDent, as may be revised, from time to time. Copies of the statement of fees for ElderDent will be available from both ElderDent and the Center, upon request.

3. Payment for Dental Services. The Undersigned agree, jointly and exclusively, to pay ElderDent for all dental services provided to the Resident by the Dental Care Providers, upon presentation of a statement of services rendered by ElderDent. In the event any statement is not paid in full, within sixty (60) days following the date of treatment:: the Undersigned shall pay to ElderDent a late fee equal to Five Percent (5%) of the amount payable under the statement,. Interest shall accrue daily on all amounts remaining unpaid within such sixty (60) day time period at a rate of 1.5% per month. ElderDent shall have no obligation to provided services to the Resident during any period when any statement has not been paid in full within the time period set forth herein.
4. Collection Costs. The Undersigned agrees to reimburse ElderDent for all costs and expenses, including legal fees and court costs, it may incur in collecting any amounts payable by the Undersigned hereunder. Should your account be placed with a collections agency there will be an initial fee of $20.00 added to your balance due.
5. Governing Law. This Consent is being delivered and is intended to be performed in the Commonwealth of Pennsylvania, and shall be enforce and construed according to the laws of that State. The Undersigned hereby agree that jurisdiction and venue for any dispute hereunder shall lie exclusively in Montgomery County, Pennsylvania, and hereby agree to accept service of any pleadings and court process by certified mail in lieu of personal service.

ACKNOWLEDGED AND AGREED, INTENDING TO BE LEGALLY BOUND:

RESIDENT:

_____(Signature)
Name:_____
SSN:_____

RESPONSIBLE PARTIES:

_____(Signature)
Name:_____
Address:_____
_____

ElderDent

P. O. Box 482 Spring House, PA 19477