P. Randall Eckman, DDS, MAGD
Philip R. Eckman, Jr., DDS
966 E. Baltimore Pike
Kennett Square, PA 19348
info@eckmandds.com
(610) 388-0223

Patient Information

First Name: _____ MI: _____

Last Name: _____

Title: (please circle) Dr. Mr. Mrs. Ms. Gender: (please circle) Male Female

How do you wish to be addressed: _____

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

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

Emergency Contact Name: _____ Phone Number: _____

Dental Insurance Information

Employee/Subscriber: First Name _____ Last Name _____

Date of Birth: _____ Subscriber ID # _____

Group/ Employer Name: _____ Group Number: _____

Insurance Company Name: _____

Claim Mailing Address: _____

_____

_____

Telephone Number: _____

- I authorize payment of insurance benefits directly to **P. RANDALL ECKMAN, DDS**
- I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.
- I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.
- I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental insurance benefits.

Patient/Guardian Signature: _____ Date: _____

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Patient Medical and Dental History

Do you have history of major illness or hospitalization? **YES** **NO**

If **YES**, please explain _____

Do you have a primary care physician? **YES** **NO**

Physician _____ Phone# _____

Are you allergic to Penicillin? **YES** **NO**

Please list all known drug allergies _____

Do you require antibiotics before dental treatment? (e.g. joint replacement, heart valve condition) **YES** **NO**

if **YES**, please explain why _____

Are you taking blood thinners? **YES** **NO**

Have you taken medication for osteoporosis or bone disease? **YES** **NO**

Have you had radiation to the head and or neck? **YES** **NO**

Do you smoke or use tobacco? **YES** **NO**

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD)? **YES** **NO**

Have there been injuries to your face, mouth or chin? **YES** **NO**

Have you been treated for any of the following?			
Heart Disease	Blood Disorder	Cancer	Stroke
Tuberculosis	Diabetes	Nervous Disorder	Epilepsy
Arthritis	High Blood Pressure	Respiratory Disease	
Liver Disease	GERD	Sinusitis	Kidney Disease

If female please answer the following:
Are you taking Birth Control Pills? **YES** **NO**
Are you Pregnant? **YES** **NO** if **YES**, # of weeks _____
Are you nursing? **YES** **NO**

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my or my child's medical status. I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____

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Medications:

Additional Information you feel we should know:

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Financial Policy Acknowledgment

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy please do not hesitate to ask any member of our front office staff.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover, and American Express. We have also partnered with **Care**Credit to offer the flexibility of deferred interest and extended payment options. Check policy: If your check is returned for any reason, we will automatically add a fee of $25 to your account balance.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense. We are participating providers with most PPO networks; however, we do not participate in any HMO/DMO networks.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

If your account becomes ninety days delinquent with no attempt at making payment arrangements, your account will be turned over to a collection agency and a fee of 25% of your outstanding balance will be added to your account to cover the cost of collection.

Important Facts About your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have (i.e., Traditional, PPO, or DMO), and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered.

Patient/Parent/Guardian Signature: _____ Date: _____

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HIPPA-ACKNOWLEDGEMENT OF RECIEPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient