TRAPPE FAMILY
DENTAL
COSMETIC & GENERAL

DEAR PATIENT,

WELCOME TO TRAPPE FAMILY DENTAL WHERE YOU CAN EXPECT STATE-OF-THE ART DENTAL CARE IN A RELAXED AND FRIENDLY ENVIRONMENT WITH A HIGH DEGREE OF PROFESSIONALISM AND SKILL DEDICATED TO YOUR ORAL HEALTH.

CREATING A PLAN OF OPTIMUM ORAL HEALTH FOR YOU IS ESTABLISHED AT THIS INITIAL EXAM. THIS APPOINTMENT WILL BE FOCUSED ON GATHERING INFORMATION ABOUT YOUR CURRENT ORAL HEALTH BY TAKING ANY NECESSARY RADIOGRAPHS, SPECIAL PHOTOGRAPHS OF YOUR TEETH, EVALUATING YOUR GUM TISSUES, ORAL CANCER SCREENING, AND A TOOTH BY TOOTH EXAM. THE INFORMATION GATHERED DURING THIS APPOINTMENT WILL GIVE US A ROAD MAP TO CREATING A HEALTHIER SMILE.

YOUR TIME IS IMPORTANT TO US AND TO HELP EXPEDITE YOUR APPOINTMENT, PLEASE CHOOSE FROM THE FOLLOWING:

-FAX THE COMPLETED FORMS TO (610)489-1563 48 HOURS PRIOR TO YOUR APPOINTMENT
-MAIL THE COMPLETED FORMS TO ARRIVE AT LEAST 48 HOURS PRIOR OR
-BRING THE COMPLETED FORMS 15 MINUTES EARLY TO YOUR APPOINTMENT.

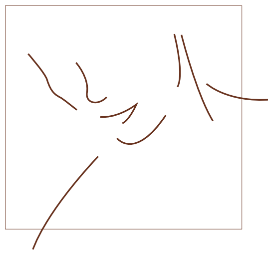
ENCLOSED YOU WILL FIND: A PATIENT REGISTRATION FORM, HEALTH HISTORY FORM, INSURANCE INFORMATION FORM, AND OUR OFFICE POLICIES.

MAKING YOUR EXPERIENCE EVEN MORE ENJOYABLE, COMPLIMENTARY MASSAGES, AS WELL AS HEATED NECK AND HAND WRAPS ARE AVAILABLE. WE LOOK FORWARD TO PROVIDING YOU A COMFORTABLE AND RELAXING DENTAL APPOINTMENT!

WHERE CARING HAPPENS. WHERE SMILES HAPPEN.

BEST SMILES,

SOO LEE, D.M.D. HAESUNG CHUNG, D.D.S.



TRAPPE FAMILY
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PATIENT INFORMATION FORM

PERSONAL INFORMATION

DATE ___/___/_______

NAME ____ WISHES TO BE CALLED ______________________

DATE OF BIRTH___/___/______ SOCIAL SECURITY NUMBER ________-_____-_______

ADDRESS ____ CITY ___________________ STATE ____ ZIP _________

HOME PHONE (___)___________ WORK PHONE (___)___________EXT._______ CELL PHONE(___)_______________

EMAIL ADDRESS _________________________ WHEN IS THE BEST TIME TO REACH YOU?______________________

SEX M F MARITAL STATUS ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

EMPLOYER ____ OCCUPATION ______________________________

EMPLOYER ADDRESS ___________________________________ CITY _______________ STATE ____ ZIP__________

EMERGENCY CONTACT NAME _______________________ RELATION ___________ HOME PHONE(___)__________

WORK PHONE: (___)______________EXT._______ CELL PHONE: (___)______________

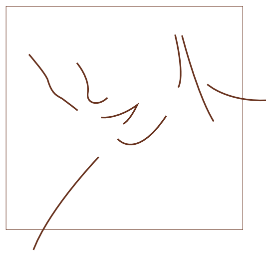
WHO MAY WE THANK FOR REFERRING YOU? _____________________________

WHO IS RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT? ________________________ RELATION ______________

DATE OF BIRTH___/___/______ SOCIAL SECURITY NUMBER ________-_____-_______

ADDRESS ____________________________ CITY _______________ STATE ____ ZIP __________

HOME PHONE (___)___________ WORK PHONE (___)___________EXT._______ CELL PHONE (___)___________



Insurance Information

Primary Insurance Coverage

SUBSCRIBER NAME ____ RELATION TO PATIENT __________________________

ADDRESS ____ CITY________________________ STATE: _____ ZIP: _________

SUBSCRIBER SS#/ID ____ SUBSCRIBER DATE OF BIRTH___/___/_____

EMPLOYER __________________________________ OCCUPATION _______________ DATE EMPLOYED ___/___/________

EMPLOYER ADDRESS ___________________________________ CITY _____________________ STATE ____ ZIP__________

INSURANCE CO. ____ GROUP # ________________

Secondary Insurance Coverage

SUBSCRIBER NAME ____ RELATION TO PATIENT __________________________

ADDRESS ____ CITY________________________ STATE: _____ ZIP: _________

SUBSCRIBER SS#/ID ____ SUBSCRIBER DATE OF BIRTH___/___/_____

EMPLOYER __________________________________ OCCUPATION _______________ DATE EMPLOYED __/___/________

EMPLOYER ADDRESS ____________________________________ CITY _____________________ STATE ____ ZIP__________

INSURANCE CO. ____ GROUP # ____________

TRAPPE FAMILY

DENTAL

COSMETIC & GENERAL

CONFIDENTIAL HEALTH HISTORY

DATE ___/___/_______

NAME ____ DATE OF BIRTH___/___/______

NAME OF PREVIOUS DENTIST ____________________________ DATE OF LAST EXAM ___/___/______

PHYSICIAN NAME _______________________ PHONE (___)_____________DATE OF LAST EXAM___/___/______

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1. HAS YOUR PRESENT HEALTH CHANGED IN THE PREVIOUS YEAR? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

2. HAS A PHYSICIAN TREATED YOU FOR ANY CONDITION IN THE PREVIOUS YEAR? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

3. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

4. IS YOUR WORK, DAILY ACTIVITY OR DIET RESTRICTED BY YOUR PHYSICIAN? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

5. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERY OR SERIOUS ILLNESS? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

6. CHECK ANY OF THE FOLLOWING MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

YES	NO		YES	NO		YES	NO	
___	___	CORTISONE DRUGS	___	___	SEDATIVES	___	___	ANTACIDS
___	___	BLOOD THINNERS	___	___	STEROIDS	___	___	ANTIDEPRESSANTS
___	___	ANTICOAGULANTS	___	___	ASPIRIN	___	___	OTHER __________
___	___	TRANQUILIZERS	___	___	VITAMINS			_______________

IF YES, PLEASE EXPLAIN THE REASON FOR EACH____
____

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

YES	NO		YES	NO		YES	NO	
___	___	ASPIRIN	___	___	DENTAL ANESTHESIA	___	___	CODEINE
___	___	HOUSEHOLD BLEACH	___	___	LATEX	___	___	PENICILLIN
___	___	OTHER _____________						
		_________________						

IF YES, PLEASE EXPLAIN ____

8. DO YOU USE TOBACCO? YES ___ NO ___ IF YES, PLEASE DESCRIBE TYPE AND QUANTITY ______

9. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? YES ___ NO ___
IF YES, PLEASE DESCRIBE TYPE, FREQUENCY AND QUANTITY ___________________________________

10. CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED:

YES	NO		YES	NO		YES	NO	
___	___	ARTHRITIS	___	___	ASTHMA	___	___	GLAUCOMA
___	___	RHEUMATIC FEVER	___	___	SINUS TROUBLE	___	___	VENEREAL DISEASE
___	___	HEART SURGERY	___	___	HAY FEVER	___	___	HIV/AIDS
___	___	HEART MURMUR	___	___	HEPATITIS A OR B	___	___	BLOOD DISEASE
___	___	CARDIAC PACEMAKER/VALVE	___	___	JAUNDICE	___	___	CANCER
___	___	HARDENING OF ARTERIES	___	___	LIVER DISEASE	___	___	LEUKEMIA
___	___	ABNORMAL BLOOD PRESSURE	___	___	TUBERCULOSIS	___	___	TUMORS
___	___	IRREGULAR HEARTBEATS	___	___	DIABETES	___	___	RADIATION TREATMENT
___	___	STROKE CHEST PAIN	___	___	SCARLET FEVER	___	___	CHEMOTHERAPY
___	___	SEIZURES	___	___	STOMACH/INTESTINAL DISEASE	___	___	JOINT REPLACEMENT
___	___	CONVULSIONS	___	___	ULCERS	___	___	BLOOD TRANSFUSION
___	___	FAINTING	___	___	ANEMIA	___	___	IMMUNE SYSTEM PROBLEMS/DISEASE
___	___	EMPHYSEMA	___	___	EXCESSIVE BLEEDING	___	___	HEMOPHILIA
___	___	LUNG DISEASE	___	___	KIDNEY DISEASE	___	___	SICKLE CELL DISEASE
___	___	CHRONIC COUGH	___	___	THYROID DISEASE	___	___	PSYCHOLOGICAL CARE
___	___	SHORTNESS OF BREATH	___	___	OTHER ______________________________			

IF YES, PLEASE EXPLAIN ____
____
____
____
____

11. WHAT IS YOUR CURRENT WEIGHT? __________LBS
HOW MUCH WEIGHT HAVE YOU GAINED/LOST IN THE LAST YEAR? +__________LBS -__________LBS

12. DO YOU WEAR CONTACT LENSES? YES ___ NO ___ IF YES, WHAT TYPE? ____________________

WOMEN ONLY: ARE YOU PREGNANT? YES ___, _____ MONTHS NO ___ NURSING? YES ___ NO ___
TAKING BIRTH CONTROL PILLS? YES ___ NO ___

DENTAL HISTORY

1. HOW OFTEN DO YOU BRUSH YOUR TEETH? ____

2. WHAT TEXTURE BRUSH DO YOU USE? ☐ SOFT ☐MEDIUM ☐HARD

3. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

4. ARE YOUR TEETH SENSITIVE TO PRESSURE OR HOT, COLD, SWEET, OR SOUR FOODS/LIQUIDS? YES ___ NO ___
IF YES, PLEASE EXPLAIN____

5. DO ANY OF YOUR TEETH ACHE OR FEEL PAIN? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

6. DOES FOOD TEND TO GET CAUGHT BETWEEN YOUR TEETH? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

7. HAVE YOU NOTICED ANY LOOSENING OR SHIFTING OF YOUR TEETH? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

8. HAVE YOU EVER HAD ANY SORES, LUMPS OR TUMORS IN OR NEAR YOUR MOUTH? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

9. HAVE YOU EXPERIENCED ANY CLICKING, POPPING, PAIN OR DIFFICULTY WHILE OPENING AND CLOSING YOUR JAWS OR CHEWING? YES ___ NO ___ IF YES, PLEASE EXPLAIN ____

10. DO YOUR HAVE FREQUENT HEADACHES? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

11. DO YOU EVER CLENCH OR GRIND YOUR TEETH? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

12. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

13. HAVE YOU EVER HAD ANY HEAD, NECK OR JAW INJURIES? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

14. ARE YOU HAPPY WITH YOUR SMILE AND TEETH? YES ___ NO ___
IF NO, PLEASE EXPLAIN
____

15. IS THERE ANYTHING YOU WISH YOU COULD CHANGE ABOUT YOUR SMILE OR TEETH? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

16. HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

17. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS OR BRUSHING YOUR TEETH?
YES ___ NO ___

IF YES, PLEASE EXPLAIN ____

18. HAVE YOU EVER HAD BRACES OR WORN A BITE PLANE OR OTHER APPLIANCE? YES ___ NO ___
IF YES, WHEN? ___________CHILD ___________ADULT

19. HAVE YOU EVER HAD PERIODONTIC (GUM) TREATMENT? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

20. HAVE YOU EVER EXPERIENCED COMPLICATIONS DURING OR AFTER DENTAL TREATMENT? YES ___ NO ___
IF YES, PLEASE EXPLAIN ____

21. IS THERE ANY QUESTION YOU DO NOT UNDERSTAND OR KNOW THE ANSWER TO? IF SO, PLEASE NOTE THE CATEGORY AND QUESTION NUMBER HERE AND THE DOCTOR WILL DISCUSS IT WITH YOU. ___________
____

22. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH THAT WE HAVE NOT COVERED IN THIS FORM?____

23. WOULD YOU LIKE TO SPEAK TO THE DENTIST PRIVATELY CONCERNING ANY PROBLEM? YES ___ NO ___

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE FOREGOING QUESTIONS. TO THE BEST OF MY KNOWLEDGE, THE FOREGOING QUESTIONS HAVE BEEN COMPLETELY AND ACCURATELY ANSWERED.

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME, TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

PATIENT/GUARDIAN SIGNATURE ______________________________DATE ___________

DENTIST'S HISTORY REVIEW: (FOR COMPLETION BY DOCTOR)

____
____
____

DOCTOR SIGNATURE ______________________________ DATE ___________

FINANCIAL POLICY

TRAPPE FAMILY DENTAL IS COMMITTED TO PROVIDING EXCEPTIONAL DENTAL CARE TO ALL OUR PATIENTS. IN ORDER TO ACHIEVE THIS GOAL, WE NEED YOUR ASSISTANCE AND YOUR UNDERSTANDING OF OUR PAYMENT POLICY.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME THE SERVICES ARE PROVIDED. IF TREATMENT REQUIRES MULTIPLE VISITS, PAYMENT MAY BE DIVIDED BY THE NUMBER OF NECESSARY VISITS. IN AN EFFORT TO PROVIDE OUR PATIENTS WITH FLEXIBLE PAYMENT OPTIONS, THE FOLLOWING FORMS OF PAYMENT ARE ACCEPTED AT THIS OFFICE. PLEASE SELECT THE OPTION THAT WORKS BEST FOR YOU.

☐ CASH ☐ CHECK ☐ VISA, MC, AMEX, DISCOVER

RETURNED CHECKS MAY BE SUBJECT TO ADDITIONAL CHARGES, AS WELL AS BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHIN **48** HOURS.

TRAPPE FAMILY DENTAL IS NOT A PARTICIPATING PROVIDER WITH INSURANCE COMPANIES (WITH THE EXCEPTION OF DELTA DENTAL PREMIER AND SCHOOL CLAIMS SERVICE); HOWEVER, AS A COURTESY TO OUR PATIENTS WITH INSURANCE, WE WILL BE HAPPY TO FILE THE INSURANCE CLAIMS ON YOUR BEHALF.

PLEASE REMEMBER THAT YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY…BUT WE CAN HELP. REGARDLESS OF WHAT WE MIGHT ESTIMATE AS YOUR DENTAL BENEFITS IN DOLLARS, WE MUST STRESS THE FACT THAT YOU, THE PATIENT, IS RESPONSIBLE FOR THE TOTAL TREATMENT FEE.

AS A COURTESY TO YOU, WE CAN ACCEPT ASSIGNMENT OF BENEFIT PAYMENTS FROM MOST INSURANCE COMPANIES. THIS WILL REDUCE YOUR IMMEDIATE OUT-OF-POCKET EXPENDITURES. IN CASES WHERE DIRECT PAYMENT IS BEING MADE BY THE INSURANCE COMPANY TO OUR OFFICE, WE WILL ESTIMATE YOUR DEDUCTIBLE AND ANY PORTION NOT COVERED BY YOUR INSURANCE. THE PATIENT PORTION (CO PAY) IS DUE AT TIME SERVICES ARE RENDERED. OUR ESTIMATES MAY DIFFER FROM YOUR INSURANCE COMPANY'S CALCULATIONS, THEREFORE, THE AMOUNT DUE WILL BE ADJUSTED ONCE PAYMENT HAS BEEN RECEIVED FROM YOUR INSURANCE.

PLEASE REMEMBER THAT YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT CONTRACTED WITH ANY INSURANCE COMPANIES AND, THEREFORE, CANNOT CONTROL WHAT INSURANCE PAYS TOWARDS TREATMENT PROVIDED. IF YOU HAVE ANY QUESTIONS REGARDING ANY OF THE INFORMATION ABOVE ABOUT YOUR INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO CALL US… WE ARE HERE TO HELP!

IT IS OUR PLEASURE TO OFFER CARE CREDIT AS A FINANCIAL OPTION TO WORK ALONG WITH YOUR INSURANCE TO MAKE IT MORE AFFORDABLE AND COMFORTABLE TO PROCEED WITH ANY RECOMMENDED TREATMENT. ASK US HOW!

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME, MY DEPENDENTS, AND/OR OTHERS ASSIGNED BY ME TO MY ACCOUNT ARE CHARGED DIRECTLY TO ME. I FURTHER UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

____ ___________________

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

TRAPPE FAMILY DENTAL

APPOINTMENT CANCELLATION POLICY

AT TRAPPE FAMILY DENTAL, APPOINTMENTS ARE MADE IN ADVANCE BY RESERVING THE APPROPRIATE TIME SLOTS TO ACCOMMODATE YOU, THE PATIENT, AND YOUR TREATMENT TO BE PERFORMED. OUR TEAM SPENDS TIME METICULOUSLY PREPARING FOR EACH APPOINTMENT BY STERILIZING, ORGANIZING AND ARRANGING THE SET UP ITEMS PRIOR TO YOUR ARRIVAL. THIS ENSURES THAT WE ACHIEVE THE HIGH STANDARD OF CARE AND TREATMENT THAT WE PRIDE OURSELVES ON. WE, THEREFORE, REQUIRE AT LEAST **48 HOURS NOTICE** PRIOR TO CANCELING OR RESCHEDULING APPOINTMENTS. PATIENTS WHO CANCEL OR RESCHEDULE THEIR APPOINTMENT WITHOUT PROPER NOTICE WILL BE ASSESSED A **$75.00** FEE TO OFFSET THE LOST PRODUCTION TIME AND ESTIMATED AMOUNT OF TIME AND EFFORT THE STAFF HAS ALREADY SPENT PREPARING FOR THE APPOINTMENT.

WE LOOK FORWARD TO ACCOMPLISHING ALL OF YOUR TREATMENT NEEDS IN A COMFORTABLE AND CARING ENVIRONMENT. PLEASE CONTACT OUR OFFICE AT **610- 489-8331** IF YOU HAVE ANY QUESTIONS OR CONCERNS.

PATIENT SIGNATURE___________________________________DATE___________________