Maedot Semo DMD
Maris Grove Dental Clinic
102 Newlin Pointe

Tel: 610-494-5556
Tel: 484-841-6926
Tel: 610-387-4520
garnetvalleydental@gmail.com

PATIENT INFORMATION

Name_____ Date of Birth_____

Cell phone_____Home Phone_____ Email_____

Address_____ Glen Mills, PA 19342

Social Security #_____ Marital Status_____

Person(s) to contact in case of emergency_____

Phone(1) _____ Phone (2)_____

BILLING and INSURANCE INFORMATION

Name of Person responsible for payment_____

Billing address if different from above_____

Please answer the following:

☐ I don't have dental insurance

☐ I have dental coverage through the Erickson Advantage Plan*

☐ Basic coverage ☐ Platinum coverage

☐ I am enrolled in a different dental insurance plan. Please provide information:

Name of Insured (if different from patient) _____ Date of Birth_____

Insurance Company _____ Phone #_____

Member ID#_____ Group #_____

Insurance Company address_____

Please provide your insurance card at the time of your visit.

***This office is an in-network provider for Erickson Advantage Dental Plan, and out-of-network for all other insurance plans.**

SIGNATURE AND CONSENT

I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

MEDICAL HISTORY FORM

Name_____ Date of Birth_____
Primary Care Provider_____ Location_____ Phone_____
Other practitioner/specialist information if relevant to your dental care:
_____

Do you need to pre-medicate with antibiotics before dental treatment? ☐ Yes ☐ No

Please provide or attach your medication list (name, dosage, condition being treated)
_____

Drug Allergies: please check if you have had an allergic reaction or a bad reaction to the following:
☐ Penicillin ☐ Local Anesthetic ☐ Codeine ☐ Sulfa Drugs ☐ Iodine ☐ Aspirin
☐ Latex ☐ Other_____

Please check if you have or have had any of the following conditions:

___ High blood pressure
___ Arrythmia
___ Pace maker
___ Chest pain (angina)
___ Mitral valve prolapse
___Cortizone therapy
___ Kidney disease
___ Liver disease
___Hepatitis A, B, or C
___ Asthma
___ Emphysema
___COPD
___ Sleep Apnea

___ Artificial heart valves
___ Heart surgery, year____
___ Stroke, year____
___ Hip/knee replacement
___ Diabetes
___ Sinus trouble
___ Anemia
____Prolonged bleeding
____Bruise easily
____Osteoarthritis
____Osteoporosis
____Rheumatoid Arthritis
____Lupus

___ Glaucoma
___Thyroid disease
___Cancer: type_____
___ Radiation
___Chemotherapy
___Autoimmune condition_____
____HIV/AIDS
____Seizures
____ Fainting/Dizziness
____Depression
____Drug Dependence
____Psychiatric treatment

Other condition, please explain_____
_____

Do you have any dental concerns at this time?_____

Have you set any goals for your dental health?
_____
_____

I understand the information contained in my records is confidential. However, I give consent for Dr. Semo to release to my physician any information which may be helpful in her understanding of my present health condition.

Signature_____ Date_____