SG Dentistry, P.C.
166 Jefferson Street
Hanover, PA. 17331
717-637-2224 office, (717)637-4827 fax
smile@sgdentistry.org

Dear Future Patient:

Our dental team is happy to welcome you to our practice. We are pleased that you have chosen us to care for your dental needs. We are committed to providing you with high quality dental care in a caring, gentle manner.

On your first visit you can expect:

~ A careful evaluation of your dental status
~ A thorough examination and assessment of your oral health, including x-rays. **If you have had x-rays taken at a previous dentist please bring them with you. If not, a full mouth series of x-rays will be performed.**
~ A discussion of the most satisfactory treatment plan to meet your oral health goals.

Enclosed is a medical and dental history form. Please complete it at your convenience and bring it along with you to your first visit. If you have dental insurance please bring your insurance information with you as well. If you have any questions concerning your insurance policy please contact your insurance provider or your human resources personnel prior to your appointment.

Our office does offer a 5% discount to our patients without dental insuance who pay by cash or check at the time of service. For your convience we accept Visa and Mastercard (5% discount not applicable with credit card payments). In addition a 10 % senior discount applies to patients who are 62 and older paying with cash or check, and a 5% discount if using a credit card.

We recognize the value of your time. Except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy.

Cordially,

Dr. Garima Purohit,
Dr. Eric Kwiatkowski,
and Staff

NEW PATIENT INFORMATION FORM

Name (last,first,middle):____
Address:____
Home Phone:________________________Work Phone:________________________
Cell Phone:________________________Sex: M/F Maritial Status: S/M/D/W/C
Social Security #:___________________________DOB:______________________
E-Mail Address:____
Referred By:____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name:_________________________Relation to Patient:_____________
Address:____
SS#:__________________Employer:____
DOB:__________________Address:____
Plan Name:____________________________________Group#:________________
Insurance Company:____
Address:______________________________________Phone#:________________

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name:_________________________Relation to Patient:_____________
Address:____
SS#:__________________Employer:____
DOB:__________________Address:____
Plan Name:____________________________________Group#:
____
Insurance Company:____
Address:______________________________________Phone#:________________

RESPONSIBLE PARTY

Name:____
Address:____

Signature:____

PATIENT MEDICAL HISTORY

Patient's Name:____________________
Address:____________________ Today's Date:__________
City, State, Zip:____________________ Cell #:__________
Home #:__________ Work #:__________ DOB:__________
Social Security #:__________ Sex:_____ Marital Status:__________
Physicians Name:____________________ Physicians #:__________
Emergency Contact Name and #:____________________
Date of Last Physical Exam:__________ Date of Last Dental Visit:__________

Please answer the following:

Do you take antibiotic pre-med? __________
Do you smoke or use tobacco products? __________
Are you taking Birth Control Pills? __________
Are you pregnant? __________

Check any of the following that you have had or suspected:

____Abnormal Bleeding
____Anemia
____Artificial Heart Valve
____Cancer
____Cosmetic Surgery
____Drug Abuse
____Fainting Spells
____Glaucoma
____Heart Murmur
____Hepatitis
____Kidney Problems
____Pace Maker
____Rheumatic Fever
____Sinus Problems
____Tuberculosis
____Jaundice

____Alcohol Abuse
____Angina
____Asthma
____Colitis
____Diabetes
____Emphysema
____Fever Blisters
____Latex Allergies
____Heart Surgery
____High Blood Pressure
____Liver Disease
____Psychiatric Problems
____Seizures
____Stroke
____Ulcers
____Prosthetic Joint Replacement (e.g. hip/knee)

____Allergies
____Arthritis
____Blood Transfusion
____Congenital Heart Defect
____Difficulty Breathing
____Epilepsy
____Frequent Headaches
____Heart Attack
____Hemophilia
____HIV/AIDS
____Low Blood Pressure
____Radiation Therapy
____Shingles
____Thyroid Problems
____Venereal Disease

Allergies:

____Asprin
____Dental Anesthetics
____Latex
____Tetracycline

____Bleach
____Erythromycin
____Metals
Other:__________

____Codeine
____Jewelry
____Penicillin

Please list any medications you are currently taking:__________
Have you had any bad experiences in other dental offices?_____ Explain:__________
____
Please list any medical/dental concerns to be addressed:__________
____

Signature:____________________