WHITELAND DENTAL

NEW PATIENT FORMS

Welcome

to Whiteland Dental

These forms help our dentists and team get to know you before your first visit, so your time with us is about you, not paperwork. About 10 minutes.

01

Fill in on screen

Open in Adobe Reader, Preview or your phone. Click a box and type. Sign by typing your name.

02

Upload securely

Save, then tap Secure Upload and add the form plus photos of your insurance card and ID. Private, encrypted, no account needed.

03

We'll call you

New patients: we call to book once your previous records arrive (up to 2 weeks). Emergency? Call 610-873-4003; we can see you right away.

PLEASE HAVE READY

- Photo ID
- Insurance card, front and back
- Your medications and doses
- Your previous dentist's name and phone

WHAT'S INSIDE

01 Patient information
02 Dental insurance
03 Dental history & smile goals
04 Medical history
05 Policies & signature
06 Records transfer authorization

W SMILE CLUB | No insurance? $379/yr: cleanings, exams, X-rays, emergencies, 30% off treatment. Plan we don't participate in? An extra 20% off. whitelanddental.com/wsmileclub.html

Patient information

Fields marked with a gold star are required. Everything you share is confidential.

01 ABOUT YOU

FIRST NAME *

LAST NAME *

PREFERRED NAME

DATE OF BIRTH (MM/DD/YYYY) *

SEX / GENDER *

MARITAL STATUS

PREFERRED LANGUAGE

MOBILE PHONE *

HOME / WORK PHONE

EMAIL *

STREET ADDRESS *

APT / UNIT

CITY *

STATE *

ZIP *

EMPLOYER / OCCUPATION

WORK PHONE

Best way to reach you

- [ ] Text message
- [ ] Phone call
- [ ] Email

May we text and email appointment reminders?

- [ ] Yes, please
- [ ] No, thank you

02 EMERGENCY CONTACT

NAME *

RELATIONSHIP

PHONE *

03 RESPONSIBLE PARTY, IF NOT THE PATIENT

NAME

RELATIONSHIP

DATE OF BIRTH

PHONE

04 YOUR VISIT

What can we help you with?

- [ ] Cleaning & checkup
- [ ] Toothache / emergency
- [ ] Broken or chipped tooth
- [ ] Dental implants
- [ ] Dentures / same-day dentures
- [ ] Invisalign / straighter teeth
- [ ] Veneers / smile makeover
- [ ] Teeth whitening
- [ ] Second opinion
- [ ] Crown or filling
- [ ] Gum health
- [ ] Something else

LAST DENTAL VISIT (APPROX.)

PREVIOUS DENTIST

HOW DID YOU HEAR ABOUT US?

REFERRED BY

ANYTHING ELSE WE SHOULD KNOW?

Dental insurance

We verify your benefits at no charge before your visit. A photo of the front and back of your card, added with your forms, is perfect.

Do you have dental insurance?

- [ ] Yes, details below
- [ ] No insurance
- [ ] Tell me about W Smile Club

W SMILE CLUB

No dental insurance? W Smile Club: $379 a year for cleanings, exams, X-rays and emergency visits, plus 30% off treatment. A plan we don't participate in? An additional 20% off the membership. Join at whitelanddental.com/wsmileclub.html or call 610-873-4003.

01 PRIMARY INSURANCE

INSURANCE COMPANY

INSURANCE PHONE

EMPLOYER / GROUP NAME

POLICY HOLDER NAME

POLICY HOLDER DATE OF BIRTH

RELATIONSHIP TO PATIENT

MEMBER / SUBSCRIBER ID

GROUP NUMBER

02 SECONDARY INSURANCE, IF ANY

INSURANCE COMPANY

INSURANCE PHONE

EMPLOYER / GROUP NAME

POLICY HOLDER NAME

POLICY HOLDER DATE OF BIRTH

RELATIONSHIP TO PATIENT

MEMBER / SUBSCRIBER ID

GROUP NUMBER

By providing insurance details you authorize us to verify eligibility and benefits and to release information needed to process claims. Benefits quoted by your carrier are estimates, not guarantees of payment.

Dental history & smile goals

A few questions so your first visit is planned around you.

01 HOW ARE THINGS TODAY?

YOUR MAIN CONCERN, IN YOUR OWN WORDS

Do you notice any of these?

- ☐ Sensitivity to hot/cold
- ☐ Jaw pain or clicking
- ☐ Dry mouth
- ☐ Stained or dark teeth
- ☐ Bleeding gums
- ☐ Bad breath
- ☐ Food catching
- ☐ Missing teeth
- ☐ Grinding / clenching
- ☐ Loose or shifting teeth
- ☐ Gaps or crowding
- ☐ Worn or chipped teeth

02 YOUR DENTAL BACKGROUND

- ☐ Yes ☐ No Are you nervous about dental visits?
- ☐ Yes ☐ No Have you had gum (periodontal) care?
- ☐ Yes ☐ No Problems with past dental work?
- ☐ Yes ☐ No Have you had braces or aligners?
- ☐ Yes ☐ No Implants, bridges or dentures?
- ☐ Yes ☐ No Do you wear a night guard?

HOW OFTEN DO YOU BRUSH?

HOW OFTEN DO YOU FLOSS?

YOUR LAST X-RAYS (APPROX.)

Comfort options you would like

- ☐ Nitrous oxide (laughing gas)
- ☐ Music or headphones
- ☐ Gentle numbing (The Wand)
- ☐ Explain each step
- ☐ Breaks during treatment
- ☐ Early-morning visits

03 YOUR SMILE

How do you feel about your smile today?

☐ 1 Unhappy ☐ 2 ☐ 3 ☐ 4 ☐ 5 Love it

IF YOU COULD CHANGE ONE THING ABOUT YOUR SMILE, WHAT WOULD IT BE?

Medical history

Your overall health shapes your dental care. All information is kept confidential.

PATIENT NAME *

DATE OF BIRTH *

HEIGHT / WEIGHT (OPTIONAL)

PHYSICIAN

PHYSICIAN PHONE

DATE OF LAST PHYSICAL

- ☐ Yes ☐ No Under a physician's care now?
- ☐ Yes ☐ No Antibiotics before dental work?
- ☐ Yes ☐ No Are you pregnant or nursing?
- ☐ Yes ☐ No Hospital stay or surgery in 5 years?
- ☐ Yes ☐ No Do you use tobacco or vape?
- ☐ Yes ☐ No Do you take blood thinners?

Have you ever had any of the following?

- ☐ Heart disease / heart attack
- ☐ Heart murmur / valve problem
- ☐ Stroke
- ☐ Diabetes
- ☐ Sleep apnea / snoring
- ☐ Kidney disease
- ☐ Cancer
- ☐ Bone drugs (Fosamax, Prolia)
- ☐ Anxiety / depression
- ☐ Tuberculosis
- ☐ High blood pressure
- ☐ Artificial heart valve
- ☐ Artificial joint (hip, knee)
- ☐ Thyroid condition
- ☐ Bleeding / clotting disorder
- ☐ Liver disease / hepatitis
- ☐ Radiation or chemotherapy
- ☐ Seizures / epilepsy
- ☐ Acid reflux (GERD)
- ☐ Eating disorder
- ☐ Low blood pressure
- ☐ Pacemaker / defibrillator
- ☐ Rheumatic fever
- ☐ Asthma / lung disease
- ☐ Anemia
- ☐ HIV / immune disorder
- ☐ Osteoporosis
- ☐ Fainting / dizziness
- ☐ Arthritis
- ☐ Organ transplant

Allergies

- ☐ Penicillin / amoxicillin
- ☐ Local anesthetic (numbing)
- ☐ Sulfa drugs
- ☐ Acrylic
- ☐ Other antibiotics
- ☐ Latex
- ☐ Metals
- ☐ Seasonal / hay fever
- ☐ Codeine / opioids
- ☐ Aspirin / ibuprofen
- ☐ Iodine
- ☐ No known allergies

OTHER CONDITIONS OR ALLERGIES

MEDICATIONS, VITAMINS & SUPPLEMENTS (NAME AND DOSE)

Policies & signature

The essentials in brief. Full policies are on our website, and we are always happy to answer questions.

Financial policy

Payment is due when services are provided unless arranged otherwise. We file insurance as a courtesy; coverage is decided by your carrier and estimates are not guarantees. Balances over 30 days may incur up to 1.5% per month, or the maximum allowed under Pennsylvania law.

Appointments

Your time is reserved just for you. Please give 24–48 hours' notice to reschedule. Missed visits or late cancellations may carry a fee; emergencies are always considered.

X-rays & insurance

X-rays are taken when the dentist judges them necessary, following ADA guidelines with low-dose digital imaging. If a recommended X-ray isn't covered by your plan, you may pay for it or decline it in writing.

Privacy & consent

Our Notice of Privacy Practices is at whitelanddental.com/hipaa-notice.html. I consent to an examination, X-rays and cleaning as needed; any further treatment and its cost will be explained first.

Full policies: whitelanddental.com/financial-policy.html · whitelanddental.com/cancellation-policy.html · whitelanddental.com/hipaa-notice.html

Please confirm

- [ ] I agree to the financial policy
- [ ] I acknowledge the X-ray & insurance notice
- [ ] I consent to examination and X-rays as needed
- [ ] I have read the appointment policy
- [ ] I can access the Notice of Privacy Practices
- [ ] You may text/email reminders and forms

Sign here Type your full name to sign electronically. Patient, or parent/guardian if under 18.

SIGNATURE * _____ PRINTED NAME _____ DATE * _____

RELATIONSHIP TO PATIENT (IF SIGNING FOR A MINOR) _____ EMAIL FOR YOUR COPY _____

OFFICE USE · CHART CREATED _____ BY _____ · ENTERED IN ASCEND [ ] · INSURANCE VERIFIED [ ]

Records transfer

So we can request your X-rays and records from your previous dentist. You don't need to call them yourself.

01 PATIENT AND PREVIOUS DENTIST

PATIENT NAME * | DATE OF BIRTH * | PHONE

PRACTICE NAME * | DENTIST NAME

PHONE * | FAX | EMAIL

STREET ADDRESS | CITY, STATE, ZIP | LAST VISIT (APPROX.)

Please send

- [ ] All records (recommended)
- [ ] X-rays (last 3 years)
- [ ] Periodontal (gum) charting
- [ ] Treatment notes & history
- [ ] Current treatment plan
- [ ] Medical history on file

02 AUTHORIZATION

I authorize the dental practice named above to release copies of my dental records, as checked above, to Whiteland Dental, 670 W Lincoln Hwy, Exton, PA 19341 (phone 610-873-4003, email info@whitelanddental.com), for the purpose of continuing my dental care. This authorization expires one year from the date I sign it, unless I revoke it earlier in writing to the practice holding my records. I understand that I may revoke it at any time, except where action has already been taken; that my treatment does not depend on signing it; and that once released, the information may no longer be protected by federal privacy rules. A copy or electronic version of this authorization is as valid as the original.

Sign here Type your full name to sign electronically. Patient, or parent/guardian if under 18.

SIGNATURE * | PRINTED NAME | DATE *

RELATIONSHIP TO PATIENT (IF SIGNING FOR A MINOR) | EMAIL FOR YOUR COPY

WHAT HAPPENS NEXT

Within minutes: a confirmation email with your forms and secure upload link. Within 1 business day: a call or text from our team. Records: we request them for you; it can take up to 2 weeks, and we call to book as soon as they arrive. In pain? Don't wait for records: call 610-873-4003 for an emergency visit. Before your visit: text and email reminders.

OFFICE USE · REQUEST SENT _____ BY _____ · RECORDS RECEIVED _____ · SCANNED TO CHART [ ]

Financial consent

Please read and sign. This consent applies to all care at our practice.

This Financial Consent is incorporated into, and made part of, any Treatment Estimate, treatment plan, or services provided to the patient named above, and applies to all care rendered by Whiteland Dental unless otherwise stated in writing.

Scope of Financial Consent
This Financial Consent is a continuing agreement governing all care provided at Whiteland Dental — preventive, diagnostic, restorative, endodontic, surgical, implant, prosthodontic, orthodontic, and emergency. It remains in effect for current and future treatment unless modified in writing. I authorize Whiteland Dental and its providers to perform the dental, orthodontic, implant, and/or surgical services recommended and agreed upon.

1. Payment Obligations & Accepted Methods
Full payment is due when treatment begins, even if treatment or services are completed over multiple visits. Once professional services are initiated or custom laboratory, implant, or surgical work is ordered, the service is considered rendered to that extent and payment becomes due accordingly. Any permission to divide payments across visits is a courtesy only and does not delay, reduce, or negate my obligation to pay. All estimates provided are good-faith approximations only; final charges may vary based on the services actually rendered. Accepted methods: cash, check, ACH/eCheck, debit card, HSA/FSA, credit card, and approved third-party financing (e.g., CareCredit). A 3.5% convenience fee applies to credit card payments; no fee for ACH/eCheck, debit, cash, or check. Third-party financing is subject to the financing provider's separate terms.

2. Refundability of Services
Dental, implant, and surgical treatment involves a combination of professional services, clinical time, and third-party costs, which may be treated differently under Pennsylvania law. The following are generally non-refundable once ordered, initiated, or delivered, except where required by Pennsylvania law: custom lab work; crowns, onlays, veneers, night guards, orthodontic appliances, aligners, dentures, retainers; implant components; professional services already rendered.

3. Partially Completed Treatment
Some treatments are provided in stages. If treatment is discontinued before completion, charges for services already rendered, time spent, materials used, and costs incurred are non-refundable. Any portion not yet rendered may be considered for adjustment consistent with Pennsylvania law and professional standards.

4. Missed & Late Appointments
Scheduled appointments require at least 48 hours' notice to reschedule or cancel without charge; our hygienists and providers reserve time exclusively for you. A $35 cancellation fee is assessed for hygiene/cleaning appointments cancelled with less than 48 hours' notice or missed. Other appointment types may be assessed a missed-appointment fee at the practice's then-current rate. Patients who repeatedly cancel late or miss appointments may be required to pre-pay for future appointments before scheduling, and may be discharged from the practice. Arrivals more than 15 minutes late may need to be rescheduled at the practice's discretion.

5. Insurance Pre-Determinations & Payments
Any insurance pre-determination is an estimate only and not a guarantee of payment. Coverage decisions are made solely by my insurance carrier. I am fully responsible for all charges, including services not covered, partially covered, denied, or not reimbursed. Whiteland Dental is not responsible for insurance payment outcomes. I authorize payment of insurance benefits directly to the practice where applicable. The practice works with third-party administrators to prepare and submit insurance pre-determinations and claims where applicable. A $19 administrative fee may be assessed per insurance submission or pre-determination request to cover third-party processing and documentation costs. This fee is disclosed at the time of the request and is separate from any treatment charges.

6. Assignment of Benefits & Release of Information
I assign all insurance benefits payable to me to Whiteland Dental and authorize direct payment. I authorize the practice to release to my carriers, TPAs, and payors any information — including PHI permitted for treatment, payment, and health-care operations under HIPAA (45 CFR 164.506) — reasonably required to determine coverage or secure payment. This assignment remains in effect throughout my treatment unless revoked by me in writing.

7. Financial Responsibility for Minors & Guarantor
If the patient is a minor, I certify that I am the parent or legal guardian and I personally accept financial responsibility for all charges incurred for the minor's care, without regard to insurance coverage or the terms of any divorce, custody, or support order between me and any other party. This obligation continues until the minor reaches the age of majority under Pennsylvania law. If a person other than the patient signs below as guarantor, that person accepts the same personal financial responsibility jointly and severally with the patient.

8. Dental & Surgical Services (Multi-Stage)
Multi-stage treatment (implant placement, grafting, augmentation, healing, abutments, provisionals, final crowns, follow-ups) is billed based on services rendered and costs incurred at each phase.

9. Treatment Outcomes
Dental and surgical outcomes depend on biological variability. No guarantee is made regarding outcome or longevity, and complications may occur despite appropriate care; such outcomes do not automatically entitle me to a refund. If concerns arise, I agree to communicate with the practice and allow a reasonable opportunity to address them. Personal dissatisfaction alone, in the absence of clinical deficiency, does not qualify for a refund.

10. Orthodontic Retainers & Appliances
Orthodontic retainers and appliances are custom-fabricated medical devices and are generally non-refundable once fabricated, except where required by law. Initial bulk, tightness, or speech changes are normal and may require an adaptation period. Patient-requested modifications may weaken the appliance. Breakage or loss may require replacement at additional cost. Dissatisfaction related to comfort, feel, or bulk alone does not qualify for a refund.

11. Remakes, Adjustments & Premature Failure

Financial consent (continued)

Minor adjustments are typically at no charge when clinically appropriate. Remakes or replacements may be provided at no cost when concerns arise within a reasonable period and are not related to patient-specific factors (bite forces, grinding, wear, biology, or compliance). If failure is patient-related (trauma, non-compliance, missed follow-ups), additional treatment is at standard fees. The remedy is corrective care, not a refund. Courtesy adjustments do not constitute a warranty.

12. Second Opinions & Treatment by Other Providers
I may seek a second opinion or receive treatment elsewhere. Differences in clinical opinion are common and do not necessarily indicate improper care. If I have treatment modified, redone, or replaced by another provider without allowing the practice a reasonable opportunity to evaluate and address my concerns, this may limit or eliminate consideration for adjustments, remakes, or financial accommodations.

13. Ongoing & Modified Treatment
Treatment may evolve based on clinical findings. This Financial Consent applies to all phases of care, including additional, modified, or unforeseen treatment necessary to achieve appropriate clinical outcomes.

14. Right to Discontinue Treatment
I may discontinue treatment at any time and remain financially responsible for services rendered and costs incurred up to that point. Whiteland Dental may discontinue treatment in accordance with applicable professional and legal standards.

15. Late Payments & Chargebacks
I authorize Whiteland Dental to charge any credit card, debit card, HSA/FSA, or other payment method I have on file for balances unpaid 30 days after due, with reasonable notice where appropriate, unless other written arrangements exist. I agree that interest may accrue at 1.5% per month (18% annually), or the maximum permitted by Pennsylvania law, whichever is lower; interest represents compensation for delayed payment. If a chargeback is initiated for authorized and rendered services, I remain responsible for the full balance owed. A reasonable administrative fee (not to exceed $100), reflecting actual processing and documentation costs, may be assessed as permitted by Pennsylvania law.

16. Collections Costs & Attorney's Fees
If my account is referred to a collection agency, licensed collector, or attorney, I agree to pay reasonable collection costs, court costs, and attorney's fees permitted by Pennsylvania law, in addition to the unpaid balance and any accrued interest. Consent to the practice charging my card on file (Section 15) does not limit the practice's right to pursue any other lawful remedy.

17. Electronic Signatures & Communications
I consent to receiving communications from the practice — including appointment reminders, treatment-plan updates, billing statements, and financial notices — by email, secure patient portal, and text message at the phone numbers and email addresses I have provided or later update. I may withdraw consent to text messages at any time by replying STOP; message and data rates may apply. I agree that any electronic signature I provide on this Financial Consent, treatment plans, or related documents has the same legal force and effect as a handwritten signature under Pennsylvania law and the federal Electronic Signatures in Global and National Commerce Act (E-SIGN, 15 U.S.C. § 7001 et seq.).

18. Governing Law & Venue
This Financial Consent is governed by, and shall be construed in accordance with, the laws of the State of Pennsylvania, without regard to its conflict-of-laws principles. Any dispute arising out of or relating to this Financial Consent or my care shall be brought exclusively in the state or federal courts located in Chester County, Pennsylvania, and I consent to the personal jurisdiction of those courts.

19. Miscellaneous — Severability, Waiver, Entire Agreement
If any provision of this Financial Consent is held invalid, illegal, or unenforceable, the remaining provisions shall remain in full force and effect. A failure or delay by the practice to enforce any right or provision is not a waiver of that right or provision. This document, together with any Treatment Estimate, treatment plan, HIPAA authorization, and other financial forms I sign, constitutes the entire financial agreement between me and Whiteland Dental and supersedes any prior understandings on the same subject. Any amendment must be in writing and signed by both parties.

Acknowledgment
By signing below, I confirm that I have read this Financial Consent, understand its terms, had the opportunity to ask questions, and voluntarily agree to all provisions. I acknowledge that I have received or been offered a copy for my records.

PATIENT NAME *

GUARANTOR NAME (IF NOT THE PATIENT)

Sign here Type your full name to sign electronically. Patient, or parent/guardian if under 18.

SIGNATURE *

PRINTED NAME

DATE *

RELATIONSHIP TO PATIENT (IF SIGNING FOR A MINOR)

EMAIL FOR YOUR COPY