Welcome!

To help us meet your dental needs, please fill out this form completely. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

Patient Information

Name____
Last First MI

Preferred Name____________________ Title___________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Date of Birth___________________ SSN_______________

Driver's Lic. #__________________ State_______________

Address____

____
City State Zip

Phone (H)__________________ (W)___________________

(Cell) ___________________ E-mail____________________

Employer ____

School (full-time students) ___________________________

Emergency Contact Name____________________________

Emergency Contact Phone____________________________

How did you hear about us?

Referred by patient (name) __________________________

Referred by doctor (name) ___________________________

Ad in _______________ Website_________ Other ________

Dental Insurance Information

Primary Plan Member Information:

Name of Insured_____________________________

Insured's Date of Birth ________________________
Month/Day/Year

Insured's Employer __________________________

Member ID#_________________________________

Insurance Co. Name __________________________

Group #____________________________________

Insurance Co. Phone # _______________________

Insured's Relationship to Patient______________

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

X____
Responsible Party Signature

______________________ ____________________
Relationship to Patient Date

Office Policies--**We have established the following office policies. Please place your initials by each to indicate that you have read them.**

_____ Payment and/or co-payment is required in full at the time services are provided.

_____ At least 24 hours advance notice is required for all appointment changes or cancellations. Otherwise, a $25 fee is charged for each appointment so affected; an additional $25 cancellation fee is charged for appointments with specialists.

_____ If you have questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations.

_____ Please be advised that the co-payment requested for services rendered is only an estimate of what the insurance will not cover, as determined from the information provided by the insurance company. The information given to our office is *not a guarantee of payment,* and the actual insurance benefit may differ from our estimates. ***The account holder is responsible for all charges the insurance company does not pay within 45 days.***

_____ Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged directly by that company.

_____ Past due accounts (having a balance due for more than 60 days) will be charged 1.5% interest per month until account is reconciled. Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency or the Maryland State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

X____ ____________________
Responsible Party Signature Date

Dental Health History

Name______________________________________

Reason for today's visit_________________

____

Former dentist_________________________

Dentist's City/State______________________

Reason for leaving_____________________

____

Date of last exam/cleaning_______________

Date of last dental x-rays_________________

How often do you brush?________________

How often do you floss?_________________

Do you feel pain anywhere?______________

____

Would you like to improve your smile? ______

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Condition		
Sensitivity to hot or cold	**Yes**	**No**
Sensitivity to sweetness	**Yes**	**No**
Avoid one side of mouth when chewing	**Yes**	**No**
Sensitivity when biting	**Yes**	**No**
Broken/cracked fillings	**Yes**	**No**
Food collection between teeth	**Yes**	**No**
Tobacco use	**Yes**	**No**
Gums swollen or tender	**Yes**	**No**
Gums bleed frequently	**Yes**	**No**
Blisters on lips or mouth	**Yes**	**No**
Sores or growths inside Cheek/in the mouth	**Yes**	**No**
Bad breath	**Yes**	**No**
Burning sensation on tongue	**Yes**	**No**
Dry mouth	**Yes**	**No**
Accident involving jaw	**Yes**	**No**
Clicking or popping jaw	**Yes**	**No**
Frequent headaches	**Yes**	**No**
Grinding teeth	**Yes**	**No**
Jaw pain or tiredness	**Yes**	**No**
Pain around ear	**Yes**	**No**
Orthodontic treatment	**Yes**	**No**
Periodontal treatment	**Yes**	**No**

Medical Health History

Physician______________________ Phone_______________

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

____

____

____

____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Valium

Other:____

Have you ever had any of the following conditions?

☐ Artificial joint/valve ☐ Heart murmur

☐ Mitral valve prolapse ☐ Rheumatic fever

Women only:

Do you use birth control medication?	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Are you pregnant? (Due date:____________)	**Yes**	**No**

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Condition		
AIDS/HIV	**Yes**	**No**
Anemia	**Yes**	**No**
Arthritis or back problems	**Yes**	**No**
Asthma or respiratory problems	**Yes**	**No**
Blood transfusion (Date:_____________)	**Yes**	**No**
Cancer	**Yes**	**No**
Cardiac pacemaker	**Yes**	**No**
Convulsions/epilepsy/seizures	**Yes**	**No**
Diabetes	**Yes**	**No**
Excessive bleeding with surgery/extractions	**Yes**	**No**
Heart problems	**Yes**	**No**
Hepatitis or liver problems	**Yes**	**No**
High or low blood pressure	**Yes**	**No**
Kidney problems	**Yes**	**No**
Phen-Phen treatment	**Yes**	**No**
Radiation or chemotherapy treatment	**Yes**	**No**
Sexually transmitted disease	**Yes**	**No**
Stroke	**Yes**	**No**
Thyroid disorder	**Yes**	**No**
Tuberculosis	**Yes**	**No**

Other:____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

X____ _______________________
Responsible Party Signature Date

X____ _______________________
Attending Dentist Signature Date