Chart #:_____
FOR OFFICE USE ONLY

Patient Information Date:_____

Patient Name: _____ Nickname:_____
Last Legal First MI

Date of Birth: _____ Social Security Number: _____

Phone (Home): _____ (Work): _____ Fax:_____ Pager/Cell:_____

Home Address: Mailing address (if Different):

_____ _____
Street Street

_____ _____
City, State, Zip Code City, State, Zip Code

E-Mail Address:_____ **Your Employer** (if any)_____

Health Information (Will be Kept Confidential) Mark Boldly and Plainly Please

For your protection and ours, have you ever had any of the following? Please check those that apply:

- ☐ HIV +
- ☐ Artificial Body Parts
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ **DO YOU NEED PREMED?** _____
- ☐ Hepatitis (type_____?)
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Taken Phen-fen
- ☐ Rheumatic Fever
- ☐ Latex Allergy
- ☐ Glaucoma
- ☐ Active Tuberculosis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion from '77-'85
- ☐ Cancer Location:_____
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Growths
- ☐ Head Injuries
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Psychological Stress
- ☐ **Are you Pregnant** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tumors
- ☐ Ulcers
- ☐ Boniva, Actonel, Fosimax etc
- ☐ Popping/clicking or pain jaw joint
- ☐ Cocaine use past 24h (Novocaine can cause serious reactions)
- ☐ Dry Mouth
- ☐ Cavities, within past 3 yrs.
- ☐ Headaches, 1+/week
- ☐ Sleep apnea
- ☐ Difficulty chewing gum
- ☐ Bleeding gums
- ☐ **Other** (explain below)

_____
_____

- **Do you have any drug or metal allergies?** ☐ Yes ☐ No
  If yes, please explain:_____
- Are you taking any medication, including herbal medications and over the counter medications? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Emergency Person Contact Information

Name: _____ Phone Number: _____

Relationship: _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School/Work ☐ Friend/relative ☐ Internet ☐ Other

Name of person or office referring you to our practice:_____

Please continue on other side.

Responsible Party Information (if different than Patient Name)

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information On Person To Whom Insurance Policy was Issued

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Secondary Dental (not Medical) Insurance (If Applicable)

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Office Financial Policies

1. We request payment at the time of service. We do accept **checks, Visa, MasterCard, Discover Card**. If this is not possible, financial arrangements are available with approved credit; permission is granted by the responsible party to obtain a credit reference from a credit bureau for billing purposes. Payments also can be deducted automatically each month from checking or credit card accounts. ***Please let us know before treatment if a credit arrangement is needed.***
2. Statements are mailed out on the 15th. of every month, or the Friday before if the 15th. occurs on a weekend. Any patient having a balance on their account at this time will receive a statement, regardless of insurance coverage. If you move, or your address or phone number changes, and you have a balance with us, it is your responsibility to inform us of the changes.
3. **Any balance carried on an account for more than 30 days will accrue interest charges of 18% per annum. This includes any balance with an insurance claim pending**. By Maryland law, insurance companies are required to pay a properly prepared claim within 30 days of submission. All claims are submitted electronically at the close of business that day; they can not be submitted electronically unless properly prepared. A tracking number will be assigned to your claim indicating proper submission. If an insurance payment results in a credit balance owed you, we will deposit the insurance check made out to us, notify you and write you a refund check off our account within 5 business days, unless directed otherwise by you.
4. Delinquent accounts are turned over for collection and the costs of collection, including collection agency fees are assumed by the patient or responsible party. For example, should the collection agency charge a 50% collection fee, then the total amount owed will double.
5. Any estimates given will be honored for six months after the date of the estimate.
6. We request any canceled appointments be given at least twenty four (24) working hours notice. This enables us to give the time reserved exclusively for you to someone else who might be in pain rather than stay overtime. While we realize sometimes unforeseen events do occur, patients who fail to give adequate notice or miss numerous appointments **may be charged** for the time missed.

Based upon all of the above, after explanation of the procedures to be performed, I give consent for dental treatement on myself or the dependent in my charge as shown on the front of this information sheet. My signature acknowledges acceptance of these terms, and also authorizes this office to file any insurance claims and discuss them with my carrier on my behalf.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian