Name (Last, First, MIddle):_____ Title:_____

Home Address:_____ Zip Code:_____

Preferred Name:_____ SS #:_____-_____-_____ DOB:____/____/____

Home Phone:_____ Work Phone:_____ *Marital:* S / M / D / W *Sex:* M / F

Cell Phone:_____ E-mail:_____

How did you hear about our office?:_____

Are any other family members patients of this office? Name:_____ Relationship:_____

Who is responsible for payment of this account?:_____

Employer:_____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name:_____ Relationship to patient:_____

Address (if different):_____

SS #:_____-_____-_____ Alternate Member ID:_____

Employer:_____

DOB:____/____/____ Employer Address:_____

Plan Name:_____ Group #:_____

Insurance Co:_____

Insurance Address:_____ Phone #:_____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name:_____ Relationship to patient:_____

Address (if different):_____

SS #:_____-_____-_____ Alternate Member ID:_____

Employer:_____

DOB:____/____/____ Employer Address:_____

Plan Name:_____ Group #:_____

Insurance Co:_____

Insurance Address:_____ Phone #:_____

PATIENT TREATMENT CONSENT

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentists(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services render on my behalf or my dependents.
- **I understand that Dental Associates, L.L.C., reserves the right to pursue delinquent accounts via a third party collection agency or attorney. In the event Dental Associates, L.L.C., refers my bill for collection, I agree to pay, for collection and/or legal services, an additional thirty percent (30%) of the amount owed.**

Preferred method of payment:

- ☐ Payment in full by cash / check
- ☐ Payment in full by VISA / MC
- ☐ Copayment in full

Date: _____

Patient / Parent or Guardian Signature:_____ **(SEAL)** **Update:** _____

REGISTRATION

Name:_____ **Date of Birth:**_____ **Date:**_____
(Last) (First) (Middle)

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:	**YES**	**NO**
Any Heart Problems	☐	☐
Heart Attack	☐	☐
Angina	☐	☐
Bypass	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Cholesterol*	☐	☐
Heart Murmur*	☐	☐
Heart Valve Defect*	☐	☐
Heart Valve Replacement*	☐	☐
Rheumatic Fever*	☐	☐
Artificial Joint (Hip / Knee)*	☐	☐
Any Bleeding Disorders	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Sickle Cell Trait	☐	☐
Blood Transfusions	☐	☐
Stents	☐	☐
Fever Blisters	☐	☐
IBS/Colitis	☐	☐
Bone Pins, Plates, Screws or Rods	☐	☐

	YES	**NO**
Do you smoke/chewing tobacco	☐	☐
Lung / Breathing Problems	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Sinus Trouble	☐	☐
Diabetes	☐	☐
Difficulty in Healing	☐	☐
Liver Problems / Dysfunction	☐	☐
Hepatitis A, B, C, or other	☐	☐
Kidney Problems / Dysfunction	☐	☐
Stomach Trouble / Acid Reflux	☐	☐
Alcohol Consumption, Daily, Weekly, Socially	☐	☐
Drug Abuse	☐	☐
Anxiety or Mental Disorder	☐	☐
Epilepsy or Seizures	☐	☐
Thyroid Problems	☐	☐
Adrenal / Pituitary Problems	☐	☐
Jaundice	☐	☐
Herbs/Supplements	☐	☐
Aspirin Therapy	☐	☐
Allergies	☐	☐
Hearing or Vision Problems	☐	☐

	YES	**NO**
Allergic Reaction to: (Hives / Swelling)		
Penicillin	☐	☐
Erythromycin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Local Anesthetic (Novocain)	☐	☐
Latex	☐	☐
Metals	☐	☐
Jewelry	☐	☐
Other _____	☐	☐
Are you aware of being allergic to any other medications or substances? Please list below:		
_____		
_____		
Sexually Transmitted Diseases	☐	☐
Other Infectious Diseases	☐	☐
HIV / AIDS	☐	☐
Cancer / Tumor	☐	☐
Other Growths	☐	☐
Chemotherapy / Radiation Therapy	☐	☐
Have you ever taken Phen Phen or Redux	☐	☐
Are you Pregnant/Nursing	☐	☐

*Do you take antibiotic premedication prior to dental appointments? ☐Yes ☐No ☐Don't Know Name of Antibiotic:_____

Are you currently being treated by a physician/specialist? ☐Yes ☐No Why? _____

Physician's name, address & phone #: _____

Any hospitalizations, procedures or surgeries: _____

Are you presently taking any medications, vitamins, herbs, pills or tonics? List:_____ For:_____

(I.E., Blood Pressure, Birth Control, Steroids, Hormones) _____ For:_____

_____ For:_____

Is there any condition or problem relating to your medical history that has not been mentioned? ☐Yes ☐No Explain: _____

_____

DATE	INTERVIEWER NOTES

Premedication Recommended: ☐Yes ☐No
Reason:_____ Rx:_____
Medical Alert Recommended: ☐Yes ☐No
1) _____
2) _____
3) _____

Medical History Review & Updates

DATE	NO CHANGE	CHANGE	LIST CHANGES:	**PATIENT/GUARDIAN SIGNATURE**	DOCTOR/HYGIENIST SIGNATURE
	☐	☐			
	☐	☐			
	☐	☐			

MEDICAL HISTORY

Name: _____ **Date of Birth:** _____ **Date:**_ _____

What is the reason for this appointment?_____

Last dental appointment: _____ Last Full mouth x-rays or Panorex _____

Describe your dental health: ❑ excellent ❑ good ❑ fair ❑ poor

1. Do you think you have cavities? Yes❑ No ❑
2. Are you happy with the appearance of your teeth? Yes❑ No ❑
3. Are your teeth all in alignment (straight)? Yes❑ No ❑
4. Have you ever had braces? Yes❑ No ❑
5. Do you wish the color of your teeth could be whiter? Yes❑ No ❑
6. Do you have:

Chipped teeth	❑	Protruding	❑
Spaces	❑	Hidden teeth	❑
Crowding	❑	Discolored teeth	❑

7. Do you clench or grind your teeth? Yes❑ No ❑
   Do you think your teeth are worn down? Yes❑ No ❑
8. Do you have dentures, partials, crowns, bridges or fillings that you are not happy with? Yes❑ No ❑
9. Do your gums bleed easily when you brush or floss? Yes❑ No ❑
10. Have you ever had gum treatments or deep cleaning? Yes❑ No ❑
11. Do you feel your breath is offensive at times? Yes❑ No ❑
12. Have you experienced any pain or soreness in the muscles in your face or around your ear? Yes❑ No ❑
13. Do you have any TMJ cracking or pain? Yes❑ No ❑
14. Do you have any swelling, lumps or bumps in your mouth or neck? Yes❑ No ❑
15. Have you ever had any complications from an extraction? Yes❑ No ❑
16. Have you ever had prolonged bleeding from an extraction? Yes❑ No ❑
17. Rate your smile
    Beautiful ❑ Inviting ❑ Average ❑ Flawed ❑ Unattractive ❑ Other ❑
18. Have you ever experienced difficulty getting numb? Yes❑ No ❑
19. Have you ever had an unfavorable dental experience? Yes❑ No ❑

I certify that the above information is complete and accurate:

_____

Patient / legal guardian Date

_____

Dentist Date

DENTAL HISTORY

DENTAL ASSOCIATES, LLC

PADONIA DENTAL ASSOCIATES
109 OLD PADONIA ROAD
COCKEYSVILLE, MD 21030

To Our Private Insurance Patients

As a courtesy to you, we will be happy to submit for pre-authorization and/or payment to all insurance companies with a completed and signed insurance form.

Due to escalating overhead and increasing paper work, we will initially ask you for only your estimated co-insurance payment. Please understand that this is only an estimate, and is based upon the accuracy of the information available to us from your insurance provider. We will also be unable to carry balances unpaid by the insurance carriers longer than 90 days after the initial submission of claims. After three months, we will require all patients to pay the balances in full and be reimbursed directly from their insurance companies. We reserve the right to pursue all delinquent accounts via a third party collection agency or attorney.

Please familiarize yourself with your dental benefits so as to be aware of deductibles, time restraints, yearly maximums, and your percentage of financial responsibility.

We would like you to **understand fully the ultimate responsibility for payment is yours.**

To Our HMO Patients

The patient is responsible for eligibility in their insurance program. Patients not listed on our insurance printout are responsible for payment in full at time of treatment.

Due to greatly reduced fees, all patient co-payments are due at the time of service.

Please familiarize yourself with your individual plan benefits to ensure that you are **aware of your financial responsibility** for any service we might perform for you.

All Patients:

All patients are responsible for payment in full at the time of service.

Endodontic (root canal) therapy may be necessary subsequent to treatment of teeth having existing deep filings or decay close to the nerve. This could occur on teeth having no previous symptoms.

****AII patients under the age of 18 must be accompanied by a parent or legal guardian on all visits.**

We reserve the right to charge for broken or missed appointments without 24 hours notice. A fee of $15.00 per 15 minutes may be assessed for failure to notify the office.

**A $35.00 service charge will be assessed for all returned checks.

ALL PATIENTS:

We require all patients over the age of 18 to provide us with their Social Security number. Though many insurance companies have unique identification numbers, they are subject to change when your insurance changes. When insurance is involved**, we ask you to remember that we are extending credit to you by collecting only percentage or co-insurance payment and billing your insurance company for the balance.** In addition, we ask that you remember that your name and date of birth not always enough to uniquely identify you for records purposes. If you prefer not to make this information available to us we will require cash payment in full at the time of your visit.

I have read and fully understand the terms stated above.

Signature: _____ Date: _____

Office Policies Revised *4/10*