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REGISTRATION FORM

PLEASE complete and email and/or bring forms with you to your appointment

PLEASE PRINT

DATE_____

NAME_____ AGE_____
BIRTHDATE_____

SOCIAL SECURITY #_____SEX_____ HEIGHT_____
WEIGHT_____

ADDRESS_____
_____

CITY_____ STATE_____ ZIP CODE_____ MARITAL STATUS_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

EMAIL ADDRESS_____

REFERRED BY_____ FAMILY DENTIST_____

FAMILY M.D._____ M.D PHONE #
_____

PHARMACY NAME_____PHARMACY PHONE #
_____

OCCUPATION _____ EMPLOYED BY
_____

IF STUDENT, NAME OF SCHOOL_____

NAME OF PARENT/SPOUSE_____
____

ADDRESS (IF DIFFERENT)

_____

HOME PHONE_____WORK PHONE_____

EMERGENCY CONTACT
NAME/RELATION/PHONE#_____

INSURANCE – MEDICAL _____
GROUP#_____

INSURED NAME _____
ADDRESS_____

INSURED BIRTHDATE_____ID or SS#_____

INSURANCE – DENTAL _____
GROUP#_____

INSURED NAME _____
ADDRESS_____

INSURED BIRTHDATE_____ID or SS#_____

PERSON RESPONSIBLE FOR ACCOUNT

_____

METHOD OF PAYMENT: CREDIT/DEBIT CARD CHECK CASH (CIRCLE ONE)

PLEASE CONTINUE TO NEXT PAGES

Office Financial Policy

Our fees are meant to be fair and reasonable. To make payments convenient for you, we accept cash, personal and business checks, Visa, Master Card. ***Payments are due at the time services are rendered, and patients not having any insurance are expected to pay in full the day of service unless a payment plan has been prearranged for larger cases.*** Please discuss any issues with the front that this may cause before being seen.

Insured patients should become familiar with the benefits and limitations of their plan. If your insurance needs a referral for coverage, it is your responsibility to bring one before surgery or you will be responsible for payment of the services rendered. If your plan has a Maximum or Cap, insurance will pay no more once the maximum has been met, expecting the remainder to become the insured's responsibility. There is a chance your insurance may not cover the services rendered. You are ultimately responsible for your bill, subject to your insurance policy's coverage.

If your account is turned over to our collection service because of non-payment, a collection fee will be added to cover their charge to us for recovery, based as follows: 25% over $500 balance; 35% for a $100 up to $500 balance; and 50% up to $100 balance. Any checks returned to our office due to insufficient funds are subject to an additional fee of $25.00. Immediate remittance in the form of cash, money order or certified funds is expected.

If at any time you have a question about this policy or your account, please do not hesitate to contact our office. (301)926-4800.

DISCLAIMER ANY QUOTE OF BENEFITS OR MONEY PAID DAY OF SURGERY IS AN ESTIMATE, ***NOT A GUARANTEED AMOUNT.*** THE MONEY IS A DOWN PAYMENT TO BE CORRECTED ONCE INSURANCE TELLS OUR OFFICE THE DEFINITE AMOUNT THE PATIENT IS EXPECTED TO PAY. Any difference according to the insurance explanation of benefits will be billed or refunded to the patient after the insurance payment has been received.

I authorize release of information needed to process my claim and assign insurance benefits.

HIPAA: I UNDERSTAND THE OFFICE FOLLOWS HIPAA REQUIREMENTS GUIDELINES.

I HAVE READ THE ABOVE POLICY AND AGREE BY SIGNING BELOW TO ACCEPT FINANCIAL RESPONSIBILITY FOR THE TREATMENT GIVEN BY THIS OFFICE PER MY INSURANCE

PATIENT NAME_____DATE

_____

SIGNATURE: PERSON RESPONSIBLE FOR BILL_____

IF OVERPAID, REFUND CHECK SHOULD BE ISSUED TO:
_____

MEDICAL HISTORY QUESTIONNAIRE

NAME_____
DATE_____

- ❖ *In the following questions please **CIRCLE** yes or no, whichever applies, your answers are for our records only and will be considered confidential.*

1. YES NO Are you in good health?
_____

2. YES NO Has there been any change in your general health in the past year?
_____

My last physical exam was on
_____

3. YES NO Are you now under the care of a physician?
_____

If so, what is the condition being treated?
_____

The name and address of my physician:
_____

_____

4. YES NO Are you taking ANY MEDICATION including non-prescription medication? If yes please list:

_____

_____

_____

5. YES NO Do you take or have ever taken Bisphosphonates for Osteoporosis or any Cancer?

(E.g. Fosamax, Zometa, Boniva, Actonel, Reclast, Aredia, Prolia, Avastin)

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

6. YES NO Heart problems (High Blood Pressure, Heart Murmurs, Congestive Heart Failure, Heart Attack, etc.)

If Yes, Please list below:

_____

7. YES NO ASTHMA? If yes, do you use an inhaler? YES/NO, and when was your last attack?

_____

8. YES NO Respiratory problems, emphysema, bronchitis, etc.? If yes, what?

9. YES NO Central Nervous System, BRAIN (Stroke, TIA, etc.)? If yes, what?

10. YES NO DIABETES? If yes, circle ***Insulin Injections*** or ***pills***.

Your last *Blood Sugar* reading was _____

11. YES NO Liver Disease?

12. YES NO AIDS/HIV infection or any sexually transmitted diseases? **If yes, what?**

13. YES NO Thyroid problems? **If yes, what?**

14. YES NO Stomach ulcer or hyperacidity? **If yes, what?**

15. YES NO Kidney Trouble? **If yes, what?**

16. YES NO Have you had abnormal bleeding, required a blood transfusion or anemia? **If yes, why?**

17. YES NO Do you smoke? **If yes, how often?**

18. YES NO Do you drink alcohol? **If yes, how often?**

19. YES NO Do you use recreational drugs? **If yes, please list.**

_____

20. YES NO Do you have any Prosthetics? (hip, knee replacement)

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

_____

_____

21. YES NO Have you had any past surgeries in a Hospital? **If yes, please list including date(s).**

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

22. YES NO **ANTIBIOTICS?** for example: **PENICILLIN**, **Sulfa**? If so what?_____

23. YES NO Allergy to local or general anestheisa?

24. YES NO **Allergy to any other Medication? Please list**_____

_____

25. YES NO Barbiturates, sedatives, or sleeping pills, soybeans or eggs? **If yes, please specify**

_____

26. YES NO Iodine?

27. YES NO LATEX?

28. YES NO Aspirin, codeine, or other narcotics? If so, what?

_____

29. YES NO Have you had any serious trouble associated with any previous dental treatment? If so explain?

_____

30. YES NO Have you had any disease, condition, or problem not listed above that you think I should know about?

_____

31. YES NO HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE PAST 8 HOURS?

WOMEN

1. YES NO Are you PREGNANT or any chance of being pregnant?
2. YES NO Are you NURSING?
3. YES NO Do you have any problems associated with your menstrual period?
4. YES NO Are you taking birth control pills, or other hormonal therapy?

ORAL CONTRACEPTIVES MAY BE RENDERED LESS EFFECTIVE WHEN TAKEN CONCURRENTLY WITH ANTIBIOTICS. IT IS ADVISABLE TO USE ADDITIONAL FORMS OF BIRTH CONTROL WHEN TAKING ANTIBIOTICS.

Reason for today's visit_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE