CLARKSBURG DENTAL

Welcome and **Thank you** for choosing us as your oral care provider! To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to assist.

Who may we thank for referring you?

□ Doctor
□ Family / Friend — Name _____ Relationship _____
□ Flyer
□ Internet — Source (Please circle one): Office Webpage Google Facebook Other _____
□ Insurance
□ Other — Please Specify _____

Patient Information

Last Name _____ First Name _____ M.I. _____

Prefer Name _____ Date of Birth ___ / ___ /___ Social _____-_____-_____ □ Male □Female

Marital Status _____ Email _____@ _____.com

Address _____

_____

Phone Numbers H _____ C _____ W _____

Employer _____ Occupation _____

Student □ Full Time □ Part Time Name of School _____

Responsible Party (If different from above)

Name _____ Relationship to the Patient _____

Date of Birth ___ / ___ /___ Social _____-_____-_____ □ Male □Female Email _____

Address _____

Phone Numbers H _____ C _____ W _____

Contact

We send reminder as a courtesy to our patients, please provide us your best contact information below.

Phone _____ Text _____

Email _____ @ _____.com

Emergency Contact

Name _____ Relationship to the Patient _____

Address _____

Phone Numbers H _____ C _____ W _____

Insurance

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / ____ SS # / ID _____

Insurance Company _____ Phone Number _____

Employer _____ Group Number _____

Do you have a secondary insurance? □ Yes □ No If yes, Please complete the following.

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / ____ SS # / ID _____

Insurance Company _____ Phone Number _____

Employer _____ Group Number _____

Dental History

Name of the previous dentist _____ Phone number _____

What is the main purpose of today's visit _____

When was your last exam and cleaning ? _____ X-Rays _____

Did you have any of the following procedures?

- □ Periodontal Treatment (Scaling and root planning or deep cleaning)
- □ Crown / Bridges
- □ Sealants
- □ Extraction

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Patient's Full Name :

Date of Birth : _____/_____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

CLARKSBURG DENTAL

PLEASE TAKE A MOMENT TO READ OUR OFFICE POLICY, INITIAL EACH LINE AND SIGN ON THE BOTTOM. THANK YOU

____ I understand Clarksburg Dental Center submits the necessary insurance paperwork for patients at no charge as a courtesy. However, Clarksburg Dental Center has no control of it and is not responsible for how insurance companies handle claims or what benefits they pay on a claim.

____ I agree to pay for all the services rendered on my behalf and/or my dependents at the time of service.

____ I understand that insurance benefits are ESTIMATES ONLY based upon the information available to the provider by my insurance carrier; Eligibility is NOT a guarantee of payment, benefits are determined only when a claim is processed. Once the claim has been processed, any difference will be due upon receipt of a statement.

____ I understand that any unpaid insurance claims or any balances that extend beyond 30 days will be assessed a service charge of 1.5% of a $20.00 late fee per month, whichever is greater; In the event that the balance should be submitted to collection agency, a fee of $50.00 will be charged to the account; If these fees should be added to my account, I will be notified by mail; Fees are subject to change, in the event of a fee change, myself or the responsible party will be notified.

____ I understand a $20.00 charge will be applied to the account for each returned check and/or declined credit card transaction

____ Should I need to cancel or re-schedule any appointments, I agree to let Clarksburg Dental Center know at least 48 hours in advance; If an appointment is broken without an advance notice, a $30.00 broken appointment fee will be assessed per every half hour; This fee will become due as a part of my account balance, and it will need to be satisfied prior to scheduling future appointments.

____ I understand when failed, missed or cancelled appointments accumulate a total number of three times without a proper advance notice, future appointments may not be scheduled and Clarksburg Dental Center has right to ask to seek services at another dental practice.

I HAVE READ THE ABOVE POLICIES, AGREE TO AND HAVE HAD THE OPPORTUNITY TO HAVE ALL MY QUESTIONS ANSWERED.

Patient's Full Name (Please Print) _____

Parent or Guardian's Full Name (Please Print) _____

Signature of Patient, Parent, or Guardian _____ Date _____

23212 Brewers Tavern Way Clarksburg, MD 20871 T301.515.5525 F301.515.9339 info@clarksburgdentalmd.com

CLARKSBURG
DENTAL

HIPAA CONSENT

I understand that I have the right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involving in my treatment)
- Obtaining payments from their party payer (e.g. my insurance company)
- The day-to-day healthcare operation of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected healthcare information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions. I understand that I may revoke this consent in writing at any time, however, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Patient's Full Name (Please Print) _____

Parent or Guardian's Full Name (Please Print) _____

Signature of Patient, Parent, or Guardian (Seal) _____ Date _____
