PATIENT INFORMATION

❑ Mr. ❑ Mrs.
❑ Ms. ❑ Miss
❑ Dr.

NAME _____
LAST FIRST MI

❑ Male ❑ Female

Pronounced _____ How should we address you? _____

How were you referred to our office? ❑ Magazine Ad ❑ Newspaper Ad ❑ Radio Ad ❑ Web Site
❑ Seminar ❑ Yellow Pages ❑ Other _____

Whom may we thank for referring you? _____

Patient
Birthdate _____ Age _____ S.S. # _____ Marital Status _____

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____
E-Mail _____ Cell Phone _____
Employer _____ Occupation _____ Years Employed _____
Employer Address _____ City _____ State _____

Spouse's Name _____ Birth date _____
LAST FIRST MIDDLE

Home Phone _____ Cell _____ Work Phone _____

Employer _____ Occupation _____ Years Employed _____

DENTAL INSURANCE INFORMATION

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, regardless of insurance coverage, and is due and payable at the time services are rendered unless financial arrangements have been made.

PRIMARY

Policy Holder's Name _____ ID # _____
Dental Insurance Company _____ GROUP # _____
Claims Address _____
Policy Holder's Employer
Subscriber Birthdate _____ Subscriber Social _____

SECONDARY

Policy Holder's Name _____ ID # _____
Dental Insurance Company _____ GROUP # _____
Claims Address _____
Policy Holder's Employer _____

EMERGENCY NOTIFICATION INFORMATION

Name _____ Home Phone _____ Other Phone _____
Name _____ Home Phone _____ Other Phone _____

PATIENT RIGHTS & CONSENT

The dental and medical profiles I have provided are complete and accurate. I request the dentist, the practice and qualified staff to perform assessment and diagnostic procedures for the purpose of determining my oral health condition and treatment options (including X-rays and photographs). As a patient, I understand that I have the right to:

- Be advised of the benefits, options and risks of any dental procedure
- Ask questions and receive complete answers regarding my oral health
- Make an informed decision to accept or decline recommended treatment

I authorize the practice to consult with or transfer my dental records to/from a medical doctor, specialist or another dentist if necessary or requested. I authorize the use of photography for lecturing and educational purposes. I authorize the practice to exchange information with my insurance providers (if any) for the purpose of administering my claims.

❑ Patient
❑ Guardian _____ Signature _____ Date

HEALTH HISTORY

NAME _____
LAST FIRST MI

YOUR PRIMARY PHYSICIAN'S NAME _____ LAST VISIT _____

ARE YOU BEING TREATED BY A PHYSICIAN NOW? ❑ YES ❑ NO

IF YES WHY? _____

ANY RECENT SERIOUS ILLNESS? ❑ YES ❑ NO

EXPLAIN _____

ARE YOU PRESENTLY (OR RECENTLY) TAKING ANY MEDICATIONS? (including non-prescription drugs) ❑ YES ❑ NO ❑ SEE ATTACHED

IF YES, WHAT? _____ FOR WHAT? _____

DAILY ASPIRIN THERAPY? ❑ YES ❑ NO FOR **WHAT?** _____

***Any medical reasons that require you to take an antibiotic prior to any dental treatment ❑ Yes ❑ No**

If yes what antibiotic are you required to take: _____

Please check yes or no to the following which you have had or have at present:

Yes	No		Yes	No		Yes	No	
❑	❑	Acid Reflux	❑	❑	Dry Mouth	❑	❑	Respiratory Problems
❑	❑	AIDS (HIV)	❑	❑	Epilepsy/Seizures	❑	❑	Rheumatic/Scarlet Fever
❑	❑	Anemia	❑	❑	Hear Loss/Deaf	❑	❑	Seasonal Allergies
❑	❑	Artificial Heart Valve	❑	❑	Heart Disease	❑	❑	Sinus Trouble
❑	❑	Artificial Joints	❑	❑	Heart Murmur	❑	❑	Sjogrens Syndrome
❑	❑	Arthritis/Rheumatism	❑	❑	Heart Pacemaker	❑	❑	Sleep Apnea
❑	❑	Asthma	❑	❑	Heart Surgery	❑	❑	STD
❑	❑	Blood Disorder	❑	❑	Hepatitis B or C	❑	❑	Stroke
❑	❑	Blood Thinner_____	❑	❑	Herpes/Fever Blister	❑	❑	Thyroid Disease
❑	❑	Blood Transfusion	❑	❑	High Blood Pressure	❑	❑	Tuberculosis
❑	❑	Cancer Treatment	❑	❑	Kidney Problems	❑	❑	Ulcers
❑	❑	Cosmetic Surgery (Facial)	❑	❑	Liver Disease			
❑	❑	Diabetes	❑	❑	Mitral Valve Prolapse			
❑	❑	Dizziness/Fainting	❑	❑	Nervous Disorder			
❑	❑	Drug Addiction	❑	❑	Psychiatric Treatment			

Are you allergic or have you reacted adversely to any of the following medications?

Yes	No		Yes	No		Yes	No	
❑	❑	Local Anesthetic	❑	❑	Percocet	❑	❑	Erythromycin
❑	❑	Latex	❑	❑	Iodine	❑	❑	Valium
❑	❑	Nitrous Oxide	❑	❑	Codeine	❑	❑	Penicillin/Amoxicillin
❑	❑	Fluoride	❑	❑	Aspirin	❑	❑	Other Antibiotic Allergy
❑	❑	Vaseline Allergy	❑	❑	Narcotic Allergy	❑	❑	Sulfa Allergy

Allergy to other medications, substances or metals? _____

PATIENT SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

Our office is dedicated to the concept that all people should have the opportunity to retain their natural teeth for a lifetime. Preventive measures, high quality care and good cooperation, combined with timely treatment, make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation; we will do everything we can to help you reach your goals for dental health.

DENTAL HISTORY

Patient Name:_____

Complete answers to the following questions will allow you to be treated on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any dental discomfort at this time? ❑ YES ❑ NO
2. Have you ever had any serious trouble associated with previous dentistry? ❑ YES ❑ NO
3. Does dental treatment make you nervous? ❑ YES ❑ NO
4. Date of last dental visit?_____Dentist Name:_____
   Address:_____Phone:_____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ❑ YES ❑ NO
6. Do you have or have you ever had any of the following?

Biting cheeks	❑ YES ❑ NO
Clicking Popping Jaw	❑ YES ❑ NO
Difficulty opening or closing jaw	❑ YES ❑ NO
Headaches, earaches, neck pains	❑ YES ❑ NO
Clenching/grinding	❑ YES ❑ NO
If so, when?_____	
Shifting in Bite	❑ YES ❑ NO
Do you wear a night guard?	❑ YES ❑ NO
Loose teeth	❑ YES ❑ NO
Sensitive to hot	❑ YES ❑ NO
Sensitive to cold	❑ YES ❑ NO
Sensitive to sweets	❑ YES ❑ NO
Sensitive to biting	❑ YES ❑ NO
Sensitive to chewing	❑ YES ❑ NO
Food Impaction	❑ YES ❑ NO
Do you use tobacco products?	❑ YES ❑ NO
Is so, what?_____	
Dentures	❑ YES ❑ NO
Partials	❑ YES ❑ NO
Bleeding, sore gums	❑ YES ❑ NO
Unpleasant taste/bad breath	❑ YES ❑ NO
Burning tongue/lips	❑ YES ❑ NO
Swelling/lumps in mouth	❑ YES ❑ NO
Ortho treatment? (braces)	❑ YES ❑ NO
Snoring	❑ YES ❑ NO
Fatigue/Sleepiness during the day	❑ YES ❑ NO

Financial Responsibility and Assignment of Insurance Benefits

I understand that the charges of this account remain the responsibility of the person signing this form, either: the patient, guarantor, parent, guardian or accompanying adult.

* As a service to you and/or your family or office, Frederick Smiles Dental Care LLC will be able to file your dental insurance benefits. However, please remember that insurance is not a guarantee of payment and is not to be considered as a total method of payment for our services. The patient/guarantor is responsible to pay any deductibles or patient estimated portions at the time of service.

*If for any reason the insurance company does not pay, (the undersigned) assume full responsibility of the unpaid charges. If the insurance company does not pay benefits within 60 days from our filing date, the guarantor will become responsible for the outstanding balance.

*Prices, fees, or benefits quoted in our office are estimates only. Final charges or benefits paid by the insurance company will be based on work performed and claims filed after the work has been completed.

I understand that if a check I have written for dental treatment is returned by the bank for non-sufficient funds there will be a returned check fee of $30.

I understand that unpaid balances may be subject to 1.50% (APR 18.00) monthly finance charge.

If this account becomes past due and is assigned to an collection agent, Frederick Smiles Dental Care LLC is entitled to all reasonable collection fees and/or costs of collection.

The undersigned agrees whether signed as agent, guarantor, or patient, that in consideration of the services to be rendered to the patient, the patient hereby individually obligates himself to pay the amount of the account to this office in full or other satisfactory financial arrangements must be made prior to time of patient services. Further, should it become necessary to enforce collection of the account, the undersigned(s) singularly and jointly agrees to all such collection expense. All delinquent accounts bear interest charges at the highest legal rate.

*I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Frederick Smiles Dental Care LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

I fully agree to the financial responsibilities and assignment of insurance benefits* as stated above.

X_____ _____ _____

Signature Printed Name Date

* If you do not have dental insurance, your dental insurance does not come to us, or we are not filing your benefits, these statements will not apply to you.

Notice of Our Privacy Practices
HIPAA (Health Insurance Portability and Accountability Act)
Frederick Smiles Dental Care

The HIPAA law requires us to maintain your privacy, and provide to you a copy of this notice, and to follow the terms of this notice. This notice describes how your dental and health information may be used, disclosed, and how you can access this information. Please review it carefully.

We have always and will continue to keep your dental and health information secure and confidential.

The law permits us to use or disclose your dental and health information to those involved in your treatment. For example, reviews of your file are permitted by a specialist doctor whom we may involve in your care.

We may use or disclose your dental and health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your dental and health information for our normal dental care operations. For example, one of our staff will enter your information into our computer.

We will use whatever address, telephone number or email you prefer to contact you. For example, we will send postcard reminders, and also call to remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. We may also call your workplace and if you are not available, leave a message on your voice mail or with a coworker or secretary. If preferred, we may contact you by email.

In an emergency, we may disclose your dental and health information to a family member or another person responsible for your care.

We may release some or all of your dental and health information when required by law.

You have the right to transfer copies of your dental information to another practice. We will mail your records for you.

You may request in writing that we not use or disclose your dental and health information as described above. We will let you know if we can fulfill your request.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. There will be no repercussions against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding you dental and health information privacy, please contact our office, at (301) 695-5454.

HIPAA (Health Insurance Portability and Accountability Act)
Frederick Smiles Dental Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ give Frederick Smiles Dental Care and staff permission to discuss the following:

- **Diagnosis, Prognosis, and/or Treatment Planning**
- **Test Results**
- **Scheduling Information**
- **Billing and/or Insurance Information**

With appropriate parties from my Insurance Carrier, as well as other dental or medical practitioners, where deemed necessary by the doctor.

I further authorize doctor and staff to:

- **Leave messages on my phone(s) voicemail** **INITIALS_____**
- **Leave messages at my workplace** **INITIALS_____**
- **Leave messages with my family and/or others residing in my household.** **INITIALS_____**
- **Discuss all aspects of my care (or my child's care, If minor) in this office with my spouse, significant other, or parents, as named below.** **INITIALS_____**

_____

_____

Acknowledgement

I have read the Notice of Privacy Practices of Frederick Smiles Dental Care and a copy will be provided to me upon my request.

Signed _____ Date _____

Printed Name _____

If signing as a parent or guardian, please note the name of the patient

_____