NORTH BETHESDA DENTAL DESIGN

Welcome and thank you for choosing our practice for your oral care! 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 help.

Who may we thank for referring you?

Date______________________

☐ Friends/Family Name _______________________________________ Relationship__________________________

☐ Doctor

☐ Internet Source (Ex. Google)_ ____

☐ Insurance

☐ Other Be Specific ____

Patient Information

Name____ _______________________________________ ___________

Last First Middle

Date of Birth ________/________/________ **SS#**_____________-__________-___________ **Gender** ☐ Male ☐ Female

Marital Status __________________________ **E-Mail** ____________________________________@__________________________

Address ____

Street Apt#

____

City State Zip

Phone Numbers Home __________________________ Cell___________________________ Work ___________________________

Emergency Contact ____ **Phone** _____________________________

Responsible Party (If different from above)

Name ____ **Date of Birth** _____/_____/_______ **SS#**_______-______-_________

Address ____

Street Apt# City State/Zip

Phone Numbers Home __________________________ Cell___________________________ Work ___________________________

Relationship (Please check one) ☐ Parent ☐ Spouse ☐ Guardian ☐ Other

Insurance Information

Policy Holder ________________________________ **Date of Birth** ______/_______/______ **SS# / ID #**______________________

Relationship to the Patient (Please check one) ☐ Self ☐ Parent ☐ Spouse ☐ Guardian

Policy Holder Address ____
Street Apt# City State/Zip

Insurance Company ____ **Phone** _________________________________

Employer Name ____ **Group #**__________________________

Do you have any secondary insurance? ☐ Yes ☐No If Yes, Please complete the following

Policy Holder ______________________________________ **Date of Birth** ______/______/_______ **SS# / ID #**_________________

Relationship to the Patient (Please check one) ☐ Self ☐ Parent ☐ Spouse ☐Guardian

Policy Holder Address ____
Street Apt# City State/Zip

Insurance Company ____ **Phone** _______________________________

Employer Name ____ **Group #**__________________________

Patient Dental History

Name of previous dentist____ **Phone #**________________________

What if your main purpose of today's visit? ____

Date of last visit to the dentist_____________________________________ **Last cleaning**___________________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquid/foods?	☐	☐
3. Are your teeth sensitive to sweet liquid/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Clicking in your jaw	☐	☐
7. Pain in your jaw, ear, side of face	☐	☐
8. Difficulty in opening, closing or chewing	☐	☐

	Yes	No
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?		
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Do you like your smile?	☐	☐
14. Have you thought about a smile makeover?	☐	☐

MEDICAL HISTORY

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 (if you need more space, please indicate it on the comment section on the bottom of this page).

	Yes	No	
Are you under a physician's care now?	☐	☐	If yes, please explain:____________________
Have you ever been hospitalized or had a major operation?	☐	☐	If yes, please explain:____________________
Have you ever had a serious head or neck injury?	☐	☐	If yes, please explain:____________________
Are you taking any medications, pills or drugs?	☐	☐	If yes, please list : ____________________
Do you take, or have you taken, Phen-Fen or Redux?	☐	☐	____________________
Are you on a special diet?	☐	☐	____________________
Do you use tobacco?	☐	☐	***Women** : Are you ☐ Pregnant/Trying to get pregnant ☐ Nursing
Do you use controlled substances?	☐	☐	☐ Taking oral contraceptives

Are you allergic to any of the followings? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other ____

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

☐ AIDS/HIV positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problem	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Chest Pains	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Yellow Jaundice
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, Please Explain: ____________________

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.

Patient's Name (Please print) ______________________________ Date of Birth ____________________

Signature of Patient ______________________________ Date ____________________

Signature of Parent or Guardian ______________________________ Date ____________________
(for patients under age of 18)

Notice of Privacy Practices Consent Form

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 payment from third party payers (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 (can be found on office website, www.mysmilekeeper.com). 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.

Please Print Patient's Full Name ____ Date of Birth ___________________

Name of Parents or Guardian ____

Signature of patient, parent, or guardian:____ Today's Date: _________________

Financial Policy

As a courtesy, North Bethesda Dental Design submits the necessary insurance paperwork for our patients at no charge. However, we have no control of and are not responsible for how your insurance company handles its claims or what benefits they pay on a claim; insurance companies do not guarantee payments based on the information that they provide us. You are ultimately responsible for knowing your benefits and any amount that is not covered by your insurance is your financial responsibility.

Payment is due at the time of service and if you have a balance following an insurance payment from a previous visit, you will be expected to pay it as well.

We accept payments in forms of cash, checks, Visa, MasterCard, Discover, American Express. However, a $25.00 charge will be applied to the account for each returned check and/or declined credit card transaction.

Any unpaid insurance claims or any balances that extend beyond 60 days will be assessed a service charge of 1.5% or a $20.00 late fee per month, whichever is greater. In the event that this balance should be submitted to collection agency, a collection fee (33 1/3%) will be charged to the account. The collection agency will report any unpaid balance to the major credit bureaus, if for any reason, the account is litigated, you will be responsible for all attorney and court fees. Fees are subject to change, in the event of a fee change the responsible party or patient will be notified.

We reserve time in our office for you and your family to receive care. Should you need to cancel or re-schedule any appointments, please let us know at least 48 hours in advanced. If an appointment is broken without advance notice, a $50.00 broken appointment fee will be assessed to your account. This fee will become due as a part of your account balance, and it will need to be satisfied prior to scheduling future appointments. If a patient accumulates a total of (3) three failed, missed and/or cancelled appointments without proper notice. Future appointments may not be re-scheduled and we'll ask such patient to seek services at another dental practice.

Please Print Patient's Full Name ____ Date of Birth ___________________

Name of Parents or Guardian ____

Signature of patient, parent, or guardian:____ Today's Date: _________________