Bethesda Smiles

"A smile is the universal welcome"

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____
Preferred Name: _____ Birth Date: _____
Sex: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Social Security Number: _____
Address: _____ (Street Number, Name, and/or Apt. Number)
_____ (City, State, Zip)
Cell Phone: _____ Home Phone: _____
Work Phone: _____ E-mail Address: _____
If college student, are you going to school ☐ FULL-TIME or ☐ PART-TIME
College Name: _____ College Location: _____ (city, state)
Emergency Contact Name: _____ Relationship to Patient: _____
Emergency Contact Phone Number: _____
Whom may we thank for referring you? _____

Responsible Party (If patient is under the age of 18)

Is this person currently a patient in our office? ☐ Yes ☐ No
Name: _____
Relationship to Patient: _____
Address: _____
_____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Policy Holder Information

Policy Holder is ☐ Patient ☐ Responsible Party ☐ Other
Name of Insured: _____ Birth Date: _____
Social Security Number: _____
Patient's Relationship to Insured: ☐ Spouse ☐ Child ☐ Other

Insurance Information

Insurance Company: _____
Employer: _____
Group Number: _____
Member ID Number: _____

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 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, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, pleas explain: _____ _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain:_____ _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list your medications: _____ _____

Do you take, or have you taken, phen-fen or redux? ☐ Yes ☐ No _____

Have you ever taken fosamax, boniva, actonel, or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

If you are a woman, are you? (Check those that apply)

☐Pregnant ☐ Taking Oral Contraceptives ☐ Nursing

Are you allergic to any of the following? (Check those that apply)

☐Aspirin ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Local anesthetics ☐ Acrylic ☐ Other_____

Do you have or have you had any of the following?(Check those that apply)

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

Have you ever had any serious illness not listed above? ☐Yes ☐No _____

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: _____Date: _____

APPOINTMENT POLICY

We make every effort to see all patients on time and request that you extend the same courtesy to us. Appointment times are reserved exclusively for **YOU** and will be scheduled at times best suited for the treatment involved.

Any changes in appointments greatly affect other patients.

We require a minimum notice of **48 HOURS** for any appointment changes. A fee of $50.00 will be charged for broken appointments or short notice charges. This must be paid prior to any future treatment.

FINANCIAL POLICY

In our efforts to keep dental costs at a minimum while maintaining a high level of professional care, we have established the following payment policies:

- Patients without Insurance Coverage
  Payment is expected at the time of treatment and can be paid for by:

  - Personal check-with proper identification
  - Cash
  - Credit Cards: VISA, MASTER CARD or CARE CREDIT

  These patients are also welcome to take advantage of our **In Office Insurance Plan**

- Patients with Insurance Coverage
  Certain insurance plans are accepted providing that verification of eligibility has been made prior to the appointment and that we can accept the assignment of benefits.
  Deductible and Estimated Patient Portions not covered by Insurance will be collected at the time services are rendered.
  All fees related to treatment are the full responsibility of the patient. In the event that payment is not received within 60 days from treatment or the insurance payment varies from the estimated portion, the **REMAINING BALANCE** will become the responsibility of the patient.
- Treatment consisting of several visits will require an appropriate down payment with the balance due upon completion.
- Payment plans are available and arrangements **must be made in advance** of treatment. Providing that credit qualifications are met. Payment plans will require an appropriate down payment and maybe subject to monthly finance charges.
- Any charges incurred by this office related to collection of overdue accounts will be added to the patients account.
- A fee of $25.00 will be charged for any returned checks.

We hope this information is helpful in answering some of the questions you may have regarding our office policies. Please feel free to discuss any questions you may have with us.

I have fully read the above information and agree with the terms and conditions:

_____ _____

Patient/Responsible Party signature Date

Consent for Use and Disclosure of Health Information

Please Read The Following Statements Carefully!

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy, including any revisions of our Notice, at any time by contacting:
301-656-6800

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, however we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____