



Today's Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: M F SSN: _____-_____-_____

Address/City/State/Zip: _____

_____ Email: _____

Primary Phone #: _____ Alternative number: _____

Whom may we thank for referring you? _____

Responsible Party

Insurance Co: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____-_____-_____

Subscriber Employer Name: _____

Medical Insurance

(Oral Surgery Patients only)

Insurance Co: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____-_____-_____

Subscriber Employer Name: _____

PATIENT TREATMENT CONSENT

I understand that Carroll County Dental Specialists, LLC, reserves the right to pursue delinquent accounts via a third party collection agency or attorney. In the event Carroll County Dental Specialists, LLC, refers my bill for collection, I agree to pay, for collection and/or legal services, an additional thirty percent (30%) of the amount owed.

Patient/Legal Guardian Signature: _____ (SEAL) **Date:** _____

Relationship to Patient: _____ Update: _____



Patient Health History

Please mark (x) your response to indicate your answer. Check "DK" if you Don't Know the answer to the question.

	<u>Yes</u>	<u>No</u>	<u>DK</u>		<u>Yes</u>	<u>No</u>	<u>DK</u>
Are you now under the care of a physician?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physician's Name: _____							
Phone Number: _____							
Are you in good health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Have you had an orthopedic total joint (Hip, knee, elbow) replacement?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have there been any changes in your general health within the past year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(specify joint) _____			
If yes, what condition is being treated? _____				Date of replacement: _____			
Have you had any serious illness, operation or been hospitalized in the past 5 years?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Have you had any complications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, what was the illness or problem? _____							

Do you smoke or chew tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ALLERGIES			
Do you drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	To all yes responses specify type of reaction.			
Do you use recreational drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Local Anesthetics _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Aspirin _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you had any of the following:				Penicillin _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial (prosthetic) heart valve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other Antibiotics (Specify) _____			
Previous infective endocarditic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Barbiturates, sedatives, or sleeping pills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Damaged valves in transplanted heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sulfa drugs _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congenital heart disease (CHD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Codeine or other narcotics _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unrepaired, cyanotic CHD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Metals _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repaired (completely) in last 6 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Latex _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repaired CHD with residual defects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Iodine _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Hay fever/Seasonal _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.				Animals _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since 2001, were you treated or are currently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Food _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date treatment began? _____				Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				WOMEN			
				Are you pregnant? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Number of weeks: _____			
				Taking birth control/hormonal replacement?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Nursing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MEDICATIONS

Are you currently taking an anti-coagulant, "blood thinner" such as Coumadin or Plavix? _____

Please list all medications you are currently taking:



Patient Health History Continued

Please mark (x) your response to indicate your answer. Check "DK" if you Don't Know the answer to the question.

	<u>Yes</u>	<u>No</u>	<u>DK</u>		<u>Yes</u>	<u>No</u>	<u>DK</u>
Cardiovascular disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cancer/Chemotherapy/Radiation treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chest pain upon exertion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arteriosclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congestive heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes type 1 or 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Damaged heart valves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eating disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Malnutrition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gastrointestinal disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mitral Valve Prolapse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	G.E. Reflux/persistent heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other congenital heart defects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pacemaker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hepatitis, jaundice or liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatic heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fainting spells or seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Neurological Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If yes specify: _____			
If yes, date: _____				Recurrent infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemophilia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Type of infections: _____			
AIDS or HIV infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kidney problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Night sweats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Autoimmune disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Persistent swollen glands in neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Systemic lupus erythematosus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Severe headache/migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Severe or rapid weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sexually transmitted disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Excessive urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

Have you ever had intravenous sedation or general anesthesia? _____

If yes, were there any adverse effects? _____

Have you had any serious problems associated with previous dental treatment? _____

If yes, please explain: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? _____

Please explain: _____

NOTE: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries 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 action they take or do not take because of errors or omissions that I have made in the completion of this form.

Signature of patient/Legal guardian: _____ **Date:** _____



Dental History

General Dentist: _____ Phone Number: _____

Date of your last exam: _____ Date of last dental x-rays: _____

What is the reason for your visit today? _____

Are there any specific dental problems we should be aware of? _____

How would you describe your dental health? Excellent Good Fair Poor

How often do you brush on a daily basis? _____ When do you brush? _____

Do you use dental floss? _____ How often? _____

Do you think you have any cavities? _____

Please CIRCLE yes or no answers to the following questions:

- | | | |
|---|-----|----|
| Are you unhappy with the appearance of your teeth? | YES | NO |
| Do your gums bleed easily when you brush or floss? | YES | NO |
| Do you feel your breath is offensive at times? | YES | NO |
| Have you experienced any pain or soreness in the muscles in your face or around your ear? | YES | NO |
| Do you have any jaw joint cracking or pain? | YES | NO |
| Are your teeth sensitive to cold, heat, sweets or pressure? | YES | NO |
| Do you have any areas of food impaction? | YES | NO |
| Do you clench or grind your teeth? | YES | NO |
| Do you have any swellings or lumps in your mouth? | YES | NO |
| Have you ever had an unfavorable dental experience? | YES | NO |
| Have you ever had any complications from an extraction? | YES | NO |
| Have you ever had gum treatments? | YES | NO |
| Have you ever had orthodontic treatment (Braces)? | YES | NO |
| Have you lost any teeth or had any removed other than your wisdom teeth? | YES | NO |
| Have you ever had prolonged bleeding from an extraction? | YES | NO |
| Have your missing teeth been replaced? | YES | NO |
| Are you happy with the replacement (s)? | YES | NO |

Do you have any questions or concerns? _____

I certify that the above information is complete and accurate:

Signature of patient/Legal guardian: _____ Date: _____

Dentist: _____ Date: _____



**2029 Suffolk Road, Suite B
Finksburg, MD, 21048
(410) 861-3001**

Important Insurance Information

We offer a valuable service to our patients; we file your insurance claims and predetermination of service for you at no cost. We also accept assignment on many insurance plans. This means we bill the insurance company, they pay us directly their portion of the fee, and we only collect a co-payment from the patient at the time of service. However, what makes this service very difficult is the fact that there are over 23,000 different insurance plans in the United States. Since our primary purpose is providing the highest quality dental care and service to our patients, it is not possible for us to know all there is to know about these plans.

The insurance policy is the legal contract between the policyholder (you) and the insurance company.

The insurance must answer to you, they must respond to your requests, and they will often pay you much more readily and quickly than they will a doctor's office. This is important for you to know, because YOU are responsible for your insurance, not us. A doctor has no legal power to force an insurance company to pay. But you as the policyholder have a great deal of legal power and rights regarding your insurance.

Most dental plans have limitations and restrictions. No insurance policy pays 100% of all dental fees.

Dental insurance is not meant to pay everything, it is only meant to be a supplement. Also even when a plan states that it covers a percentage of the fees – for example 80% - that is usually not entirely true.

Most plans cover only 40-50% of the fees. The amount your plan pays is determined by how much your employer paid for the plan. We will help you determine the amount of coverage your plan offers for each service we provide for you.

Our policy is to help our patients as much as possible with any and all aspects of their dental care while here in our office. This includes insurance. We have developed financial policies over the years, which help us keep focused on our purpose – quality dental care and superior service. While we do everything we can to help out patients with their insurance companies, we sometimes need your help, because only you have the legal power to deal with your insurance company regarding certain issues.

We ask that you understand and agree to these policies, so we are able to serve you better. We don't want financial issues to come between you and the dental care you deserve.

(PLEASE SEE BACK OF PAGE)



Carroll County Dental Specialists, LLC

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(410) 861-3001**

To Our Private Insurance Patients

We will prepare an estimate for the treatment that is to be performed. Please understand that this is only an estimate and is based on the accuracy of the information available to us by the insurance provider. Any difference in the estimate and the actual payment from the insurance company will be the patient's responsibility.

It is important to familiarize yourself with your dental benefits, so you are aware of all deductibles, co pays, maximums, and time restrains associated with your policy.

We would like you to understand fully that the responsibility for payment is yours.

To Our HMO Patients

The patient is responsible for eligibility in their insurance program.

Due to greatly reduced fees, all patient co-payments are due in full at the time of service.

Please review your individual plan benefits so you are familiar with your financial responsibility for any services we might perform for you.

All Patients

Patients without insurance are responsible for their full balance at the time of service.

All new patients under the age of 18 must be accompanied by their parent or legal guardian, so that all forms are completed and signed

We reserve the right to charge for broken or missed appointments without a 24-hour notice of cancellation. A fee of \$15 per 15 minutes will be assessed for failure to given proper notice to the office. A \$37.00 service charge will be applied for all returned checks.

I understand that Dental Associated, LLC, reserve the right to pursue delinquent accounts via a third party collection agency or attorney. In the event Dental Associates, LLC, refers my bill for collection, I agree to pay, for collection and/or legal services, an additional thirty percent (30%) of the amount owed.

Patient's Name _____

X _____

Signature of Parent/Guardian

(SEAL) _____

Date



Carroll County Dental Specialists, LLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
(First Name)

Please Print Name

Signature

Date

By Signing Above:

I authorize Dental Associates, LLC to discuss personal treatment and finances with the following individual(s):

Name

Relationship

Name

Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refuse to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgment
- Other (please specify)

