Carroll County Dental Specialists

Pediatric Dentistry. Orthodontics. Oral Surgery. Endodontics. Periodontics.

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: _____

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Patient Health History

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

	Yes	No	DK
Are you now under the care of a physician?	O	O	O
Physician's Name: _____			
Phone Number: _____			
Are you in good health?	O	O	O
Have there been any changes in your general health within the past year?	O	O	O
If yes, what condition is being treated?_____			
Have you had any serious illness, operation or been hospitalized in the past 5 years?	O	O	O
If yes, what was the illness or problem?			
_____			
_____			
Do you smoke or chew tobacco?	O	O	O
Do you drink alcohol?	O	O	O
Do you use recreational drugs?	O	O	O
Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment?	O	O	O
Have you had any of the following:			
Artificial (prosthetic) heart valve	O	O	O
Previous infective endocarditic	O	O	O
Damaged valves in transplanted heart	O	O	O
Congenital heart disease (CHD)	O	O	O
Unrepaired, cyanotic CHD	O	O	O
Repaired (completely) in last 6 months	O	O	O
Repaired CHD with residual defects	O	O	O
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.			
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?	O	O	O
Date treatment began? _____			

	Yes	No	DK
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	O	O	O
Have you had an orthopedic total joint (Hip, knee, elbow) replacement?	O	O	O
(specify joint) _____			
Date of replacement: _____			
Have you had any complications?	O	O	O

ALLERGIES

To all yes responses specify type of reaction.

Local Anesthetics_____	O	O	O
Aspirin _____	O	O	O
Penicillin _____	O	O	O
Other Antibiotics (Specify) _____			
Barbiturates, sedatives, or sleeping pills	O	O	O
Sulfa drugs _____	O	O	O
Codeine or other narcotics_____	O	O	O
Metals _____	O	O	O
Latex _____	O	O	O
Iodine _____	O	O	O
Hay fever/Seasonal _____	O	O	O
Animals _____	O	O	O
Food _____	O	O	O
Other _____	O	O	O

WOMEN

Are you pregnant? _____	O	O	O
Number of weeks: _____			
Taking birth control/hormonal replacement?	O	O	O
Nursing?	O	O	O

MEDICATIONS

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

Please list all medications you are currently taking:

_____

_____

_____

_____

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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.

	Yes	No	DK
Cardiovascular disease	O	O	O
Angina	O	O	O
Arteriosclerosis	O	O	O
Congestive heart failure	O	O	O
Damaged heart valves	O	O	O
Heart attack	O	O	O
Heart murmur	O	O	O
Mitral Valve Prolapse	O	O	O
Low blood pressure	O	O	O
High blood pressure	O	O	O
Other congenital heart defects	O	O	O
Pacemaker	O	O	O
Rheumatic fever	O	O	O
Rheumatic heart disease	O	O	O
Abnormal bleeding	O	O	O
Anemia	O	O	O
Blood transfusion	O	O	O
If yes, date: _____			
Hemophilia	O	O	O
AIDS or HIV infection	O	O	O
Arthritis	O	O	O
Autoimmune disease	O	O	O
Rheumatoid arthritis	O	O	O
Systemic lupus erythematosus	O	O	O
Asthma	O	O	O
Bronchitis	O	O	O
Emphysema	O	O	O
Sinus trouble	O	O	O
Tuberculosis	O	O	O

	Yes	No	DK
Cancer/Chemotherapy/Radiation treatment	O	O	O
Cheat pain upon exertion	O	O	O
Chronic pain	O	O	O
Diabetes type 1 or 2	O	O	O
Eating disorder	O	O	O
Malnutrition	O	O	O
Gastrointestinal disease	O	O	O
G.E. Reflux/persistent heartburn	O	O	O
Ulcers	O	O	O
Thyroid problems	O	O	O
Stroke	O	O	O
Glaucoma	O	O	O
Hepatitis, jaundice or liver disease	O	O	O
Epilepsy	O	O	O
Fainting spells or seizures	O	O	O
Neurological Disorders	O	O	O
If yes specify:_____			
Recurrent infections	O	O	O
Type of infections:			
Kidney problems	O	O	O
Night sweats	O	O	O
Osteoporosis	O	O	O
Persistent swollen glands in neck	O	O	O
Severe headache/migraines	O	O	O
Severe or rapid weight loss	O	O	O
Sexually transmitted disease	O	O	O
Excessive urination	O	O	O

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: _____

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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 are 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)

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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 _____ **(SEAL)** _____

Signature of Parent/Guardian **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)

_____

_____