# NEW PATIENT INFORMATION

Patient's name _____ Preferred Name _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Birth Date _____/_____/_____ Social Sec. No. _____ Marital Status: S / M / D / W Occupation _____

Emergency Contact: Name_____ Phone Number_____

If you were referred to our office, whom may we thank?_____

## RESPONSIBLE PARTY:

Name:_____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____/_____/_____ Social Sec. No. _____ Marital Status: S / M / D / W Occupation _____

## PRIMARY DENTAL INSURANCE COVERAGE:

Subscriber's Name:_____ Relationship_____ DOB: _____/_____/_____

Employer:_____ Insurance Co.:_____ Member ID/SS#_____

Ins. Co. Address:_____ Group Nbr._____

## Office Financial and Insurance Policy:

As a courtesy to you, we will submit to your primary insurance for reimbursement. If, however, your primary claim is not paid in 60 days, it becomes your responsibility for the unpaid balance. Based on the information we receive from your insurance company, we estimate to our best ability your obligation at the time of each visit. Please keep in mind that insurance is a method of assisting in reimbursement and is not intended as payment in full. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. A 1.5% finance charge will be added to your account after 90 days. Should your account be placed with any agency or attorney for collection, you agree to be responsible for all costs incurred in the collection of your account. This includes attorney's fees, interest, court costs, and any other costs associated with collecting this account.

## Appointment Policies:

In an effort to better serve you, we do our best to see you in a timely manner. To help us do so, we ask that you arrive on time for your appointment. As a courtesy to you, we confirm appointments 24-48 hours in advance. If you cannot make your appointment, we ask that you give us at least 24 hours' notice, otherwise there will be a charge.

I have read the above policy and agree to accept financial responsibility.

_____ _____

Signature of Patient (Parent or guardian, if minor) Date

# MEDICAL HISTORY

Please Answer All Questions:

Physician's Name:_____ Physician's Tel. Nbr:_____

Date of Last Physical Exam:_____/_____/_____

Are you now or have you recently been under a physician's care? Y / N

Any previous surgeries? Y / N

If Yes please explain nature and date(s):_____

_____

Gender: M / F

If female, please answer the following:

| | Y | N | |
|---|---|---|---|
| Are you taking Birth Control Pills? | ____ | ____ | |
| Are you pregnant? | ____ | ____ | If yes, # of weeks _____ |
| Are you nursing? | ____ | ____ | |

Do you smoke or use any tobacco products? If yes, how often?_____

Check any of the following that you are taking or have taken in the past:

_____ Antibiotic/Pre-Medications _____ Bisphosphonates/Osteoporosis Medications _____ Blood Thinners _____ Steroids

_____ Tranquilizers

Are you Allergic to or do you suffer ill effects from any of the following?

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ____ | ____ | Aspirin | ____ | ____ | Household Bleach | ____ | ____ | Metals | ____ | ____ | Tetracycline |
| ____ | ____ | Codeine | ____ | ____ | Ibrprofen/NSAIDS | ____ | ____ | Penicillin | ____ | ____ | Other If yes, |
| ____ | ____ | Dental Anesthesia | ____ | ____ | Jewelry | ____ | ____ | Sedatives | | | _____ |
| ____ | ____ | Erythromycin | ____ | ____ | Latex | ____ | ____ | Sulfa Drugs | | | |

**Please mark to indicate if you have or have not had any of the following diseases or problems.**

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ____ | ____ | Abnormal Bleeding | ____ | ____ | Frequent Headaches | ____ | ____ | Radiation Therapy |
| ____ | ____ | Alcohol Abuse | ____ | ____ | Glaucoma | ____ | ____ | Rheumatic Fever |
| ____ | ____ | Allergies/Hay Fever | ____ | ____ | G/I Disorder | ____ | ____ | Seizures |
| ____ | ____ | Arthritis | ____ | ____ | Heart Attack | ____ | ____ | Shingles |
| ____ | ____ | Asthma | ____ | ____ | Heart Surgery | ____ | ____ | Shunt Replacement |
| ____ | ____ | Auto-Immune Disease | ____ | ____ | Heart Valve Replacement | ____ | ____ | Sickle Cell Disease |
| ____ | ____ | ADD/ADHD | ____ | ____ | Hemophilia | ____ | ____ | Sinus Problems |
| ____ | ____ | Blood Disease | ____ | ____ | Hepatitis A or B | ____ | ____ | Sleep Disorder/Apnea |
| ____ | ____ | Blood Transfusion | ____ | ____ | Hepatitis C | ____ | ____ | Stroke |
| ____ | ____ | Cancer – Chemo | ____ | ____ | Heart Murmur | ____ | ____ | Thyroid Problems |
| ____ | ____ | Colitis | ____ | ____ | High/Low BP | ____ | ____ | Tuberculosis |
| ____ | ____ | Congenital Heart Defect | ____ | ____ | HIV/AIDS | ____ | ____ | TMJ Disorder |
| ____ | ____ | Diabetes | ____ | ____ | Kidney Problems | ____ | ____ | Ulcers |
| ____ | ____ | Difficulty Breathing | ____ | ____ | Liver Disease | ____ | ____ | Venereal Disease |
| ____ | ____ | Drug Abuse | ____ | ____ | Lung Disease | ____ | ____ | Yellow Jaundice |
| ____ | ____ | Developmental Disability | ____ | ____ | Mental Health Disorder/Anxiety | | | Other |
| ____ | ____ | Emphysema | ____ | ____ | Pacemaker/Defibrillator | | | _____ |
| ____ | ____ | Epilepsy | ____ | ____ | Pheumcystitis | | | _____ |
| ____ | ____ | Fainting Spells | ____ | ____ | Prosthetic Joint Replacement | | | |

**MEDICATIONS:**

Pharmacy:_____ Pharmacy Phone:_____

Please list all medications you are currently taking:_____

_____

Is there any disease, condition, or problem that you think we should know about that is not listed above?

_____

_____

Signature:_____ Date:_____

The information above is true to the best of my knowledge. If under 18, Parent or Guardian Signature required

# ACKNOWLEDGMENT OF PRIVACY PRACTICES

**Calvert Dental Associates**

**Robert A. Wood, D.D.S.**

**Ashlie B. Dohman, D.D.S.**

**7670 Meadow Run Lane, Owings, MD. 20736**

**301-855-8200**

My signature confirms that I have been informed of my rights of privacy regarding my protected health information under the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private my information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions but if you agree then you are bound to abide by such restrictions.

Patient Name_____Date_____

Signature_____

Relationship to Patient_____

Dependent family members also covered by this acknowledgement:

_____

*For Office use only*

We were unable to obtain the patients written acknowledgment of our *Notice of Privacy Practices* due to the following reasons:

___ The patient refused to sign

___ Communication barriers

___ Emergency situation