Family Dental Wellness Center

Patient Information

Last Name:_____ **First Name:**_____ **MI:** _____ **Birthdate:**_____

☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other** **SSN:**_____

Address:_____ **Apt. No.**_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone: (____)_____ **Work Phone :** (____)_____ **Cell Phone:** (___)_____

E-mail:_____ **Driver's License#:** _____ **ST:**_____

Employer: _____ ***How did you hear about our office*:**_____

In case of an emergency contact:_____ **Relationship:**_____ **Phone:** (____)_____

Responsible Party (If same as above please check here ■ If not, please fill out below)

Last Name:_____ **First Name:**_____ **MI:** _____ **Birthdate:**_____

SSN:_____ **Relationship:**_____ **Driver's License#:** _____ _____**ST:**_____

Address:_____ **Apt. No.**_____ **City:**_____ **State:**_____ **Zip:**_____

Employer: _____ **Employer Address:** _____

Primary Dental Insurance

Policy Holders Name:_____

Policy Holders SSN/ ID#: _____

Policy Holders Birthdate: _____

Insurance Co.:_____ **Phone#:**_____

Employer: _____ **Group#:**_____

Secondary Dental Insurance

Policy Holders Name:_____

Policy Holders SSN/ ID#: _____

Policy Holders Birthdate: _____

Insurance Co.:_____ **Phone#:**_____

Employer: _____ **Group#:**_____

Dental History

Reason for today's visit:_____ **Previous Dentist:**_____ **Phone #:** _____

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

Have you ever had any serious problems with past dental treatment? **Yes or No** ***If yes, explain:***

_____

Do you have or have you ever been treated for: Circle "Yes" or "No"

Bad Breath	YES	NO	Periodontal Treatment	YES	NO
Bleeding Gums	YES	NO	Sensitivity to hot or cold	YES	NO
Clicking or Popping Jaw	YES	NO	Sensitivity to sweets	YES	NO
Food collecting between teeth	YES	NO	Sensitivity when biting	YES	NO
Grinding teeth	YES	NO	Sores or growth in mouth	YES	NO
Loose teeth or broken fillings	YES	NO	Swelling	YES	NO
Pain	YES	NO	Reaction to local anesthetic	YES	NO

Medical History

Patient's Name:_____ **Date:**_____

Do you have or have you ever been treated for: Circle "Yes" or "No" to indicate whether you have or had any of the following conditions:

Anemia	YES	NO
Arthritis, Rheumatism	YES	NO
Artificial Devices or Joints	YES	NO
Asthma	YES	NO
Autoimmune Conditions	YES	NO
Bleeding Problems	YES	NO
Blood Disease	YES	NO
Cancer	YES	NO
Cholesterol	YES	NO
Chemotherapy	YES	NO
Circulatory Problems	YES	NO
Cortisone Treatments	YES	NO
Diabetes	YES	NO
Epilepsy	YES	NO
Fainting	YES	NO
Glaucoma	YES	NO
Headaches	YES	NO
Heart Problems	YES	NO
Heart Surgery	YES	NO
Hepatitis	YES	NO
High Blood Pressure	YES	NO
HIV/AIDS	YES	NO
Jaw Pain	YES	NO
Kidney Disease	YES	NO
Liver Disease	YES	NO
Nervous System Problems	YES	NO
Pacemaker	YES	NO

Other: _____

Psychiatric Treatment	YES	NO
Radiation Treatment	YES	NO
Respiratory Disease	YES	NO
Shortness of Breath	YES	NO
Skin Rash	YES	NO
Sleep/ Apnea	YES	NO
Snoring	YES	NO
Stroke	YES	NO
Swelling Feet/Ankles	YES	NO
Thyroid Problems	YES	NO
Tobacco Habit	YES	NO
Tuberculosis	YES	NO
Ulcer	YES	NO

If you are female, are you:		
Pregnant	YES	NO
Nursing	YES	NO
Taking Birth Contro1	YES	NO
Taking Hormone Medications	YES	NO

Bisphosphonates:		
Do you have osteoporosis?	YES	NO
Are you currently taking any bisphosphonate drug?	YES	NO
Have you ever taken any bisphosphonate drug? (e.g. Fosamax)	YES	NO

Physician: _____
Phone: _____

Please list all current medications (including prescriptions, over-the-counter, herbal supplements) and reason for use:

_____

_____

Are you allergic to: ☐Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐Valium ☐Sulfa ☐ Lidocaine ☐Other _____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health. I understand that I am responsible to inform the office of any changes to my medical and dental health.

Signature of Patient, Parent or Guardian: _____ Date:_____

Signature of Dentist: _____ Date: _____

Family Dental Wellness Center

Financial Policy

We at Family Dental Wellness Center are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services to help your family keep smiling. In order to assist you with your health care investment, we are providing the following payment options.

PAYMENT

Payment is due at the time of service. We do accept cash, personal checks with current date, major credit cards, debit cards and third party financing through Care Credit.

INSURANCE

As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are estimates only and are not a guarantee of payment. The patient is ultimately responsible for all charges incurred. Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will be resubmitted by our office and we ask that you follow-up as well. After 90 days, we ask that you pay in full and have your insurance company reimburse you. We will be happy to provide any information or documentation you may require. Our first and only priority is our patients and the quality of care. The negotiation of benefits is between you, your employer and insurance company.

RETURNED CHECKS

All returned checks are subject to $30.00 returned check fee. Any unpaid returned checks will be forwarded to the District Attorney for collection.

DELINQUENT ACCOUNTS

Delinquent accounts (having a balance due for more than 90 days) may be subject to an eighteen percent (18%) APR interest charge; in addition it may be transferred to a collection agency or the Maryland State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

CANCELLATIONS

It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities. We do require 48 hours' notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. We are then also able to offer all of our patients' the same exceptional standard of care. A fee of $45 will be charged for failed or cancelled appointments with less than 48 hours' notice.

FINANCING OPTIONS

Ask our team how we can help you with your financial needs. We offer some 0% interest plans through Care Credit (if paid back in full within the promotional period). We will be happy to help finance your treatment to allow you to begin your treatment immediately and spread the payment over time.

Acknowledgment of Receipt of Notice of Privacy Practices

I _____ have received a copy of the Notice of Privacy Practices.

_____ _____
Patient/Parent or Guardian Signature Date

_____ _____
PLEASE PRINT NAME of Patient, Parent or Guardian Relationship to Patient

For Office Use ONLY:

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

Office Manager: _____ Date: _____

Acknowledgment of Receipt of Financial Policy

I _____ have read the Financial Policy and understand and agree to these terms.
I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of benefits to be directly to FAMILY DENTAL WELLNESS CENTER.

_____ _____
Patient/Parent or Guardian Signature Date

_____ _____
PLEASE PRINT NAME of Patient, Parent or Guardian Relationship to Patient

For Office Use ONLY:

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Office Manager: _____ Date: _____