

WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____

Date of Last X-Rays _____

City, State _____

How Often Do You Floss? _____

Date of Last Dental Visit _____

How Often Do You Brush? _____

Please check all that apply:

Bad Breath.....
 Bleeding Gums
 Blisters on Lips or Mouth
 Finger Nail Biting
 Grinding Teeth
 Lip or Cheek Biting

Loose Teeth or Broken Fillings.....
 Orthodontic Treatment
 Pain Around Ear
 Periodontal Treatment
 Sensitivity to Cold
 Sensitivity to Heat

Sensitivity to Sweets
 Sensitivity When Biting
 Frequent Headaches
 Jaw, Head or Neck Injuries
 Jaw Difficulty: Clicking and/or Pain...
 Tooth Pain

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? Yes No

2. Have you ever had any serious illnesses or operations? Yes No

3. Are you currently taking any medication? Yes No

Please describe: _____

4. Do you smoke? Yes No

5. Do you use alcohol, cocaine or other drugs? Yes No

6. Do you wear contact lenses? Yes No

7. Have you had any allergic reactions to the following:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Local Anesthetics (eg. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (sleeping pills)	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

8. (Women Only) Are You:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

Please check all that apply:

AIDS
 Anemia.....
 Arthritis, Rheumatism
 Artificial Heart Valves
 Artificial Joints
 Asthma
 Back Problems
 Bleeding abnormally,
 with extractions or surgery
 Blood Disease
 Cancer
 Chemical Dependency
 Chemotherapy
 Chronic Fatigue Syndrome
 Circulatory Problems
 Congenital Heart Lesions.....
 Cortisone Treatments
 Cough - persistent or bloody.....
 Diabetes.....

Emphysema
 Epilepsy
 Fainting or Dizziness
 Glaucoma
 Headaches.....
 Heart Murmur
 Heart Problems.....
 Hepatitis-Type
 Herpes.....
 High Blood Pressure
 HIV Positive
 Jaundice
 Jaw Pain
 Latex Sensitivity
 Kidney Disease
 Liver Disease.....
 Low Blood Pressure
 Mitral Valve Prolapse.....
 Nervous Problems.....

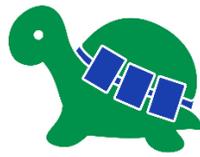
Pacemaker.....
 Psychiatric Care
 Radiation Treatment.....
 Respiratory Disease.....
 Rheumatic Fever
 Scarlet Fever
 Shortness of Breath
 Sinus Trouble.....
 Skin Rash
 Stroke
 Swelling of Feet/Ankles.....
 Swollen Neck Glands.....
 Thyroid Problems.....
 Tonsillitis
 Tuberculosis.....
 Tumor or growth on head/neck.....
 Ulcer.....
 Venereal Disease

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____



Carroll County Pediatric Dentistry & Orthodontics

Important Insurance Information

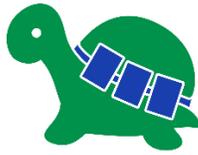
We offer a valuable service to our patients; we file your insurance claims and predetermination of service for you at no cost. We also accept assignments on many insurance plans. This means we bill the insurance company; they pay us directly their portion of the fee, and we only collect a co-payment 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 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 can 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 Pediatric Dentistry & Orthodontics

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 restraints 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 24-hour notice of cancellation.

A fee of \$15 per 15 minutes will be assessed for failure to give proper notice to the office.

A \$37.00 service charge will be applied for all returned checks.

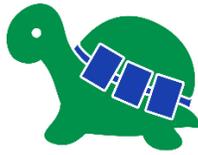
I understand that Carroll County Pediatric Dentistry and Orthodontics, LLC, reserves the right to pursue delinquent accounts via a third-party collection agency or attorney. In the event Dental Associates, LLC, refers to my bill for collection, I agree to pay, for collection and/or legal services, an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

Patient's Name _____

_____ (SEAL)

Patient/Legal guardian Signature

Date



Carroll County Pediatric Dentistry & Orthodontics

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)

Signature:

Date:

By Signing Above:

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

Name

Relationship/Phone number

Name

Relationship/Phone number

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