Frederick Dental Group ~ Registration and Health History

Patient Information:

Name: _____ DOB ____/____/____
Address: _____
City/State/Zip_____ _____
SSN: _____-_____-_____ Sex: M/F Height _____ Weight ____lbs
Home Phone ____-____-____ Cell Phone ____-____-____
Email Address: _____
Single Married Divorced Separated Widowed
Emergency Contact Number: _____
Emergency Contact Name: _____
Employer: _____
Occupation: _____Full Time or Part Time
How did you hear of our office? _____
If Google, what did you search to find us? _____

Please provide your dental & medical insurance cards so we may make a copy.

Dental Insurance Company: _____
Name of the Policy Holder: _____
Policy Holder DOB: ____/____/____ Policy Holder SSN: ____-____-____

Dental and Medical History

Primary Care Physician Name: _____
Primary Care Phone #: ____-____-____ Date of Last Physical ____/____/____
List all surgeries to date: _____
_____

Date of Last Dental Exam: ____/____/____ Date of Last X-rays: ____/____/____
Previous Dentist: _____
Reason for Leaving: _____

Please list ALL medications you are taking. OTC, Prescriptions, supplements, etc.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: Circle All that apply
Aspirin Iodine Sulfa Penicillin Latex Codeine
Tetracycline Erythromycin Local Anesthetic Other: _____

WOMEN: Are you pregnant? Y/N Due Date ___/___/___ Nursing? Y/N
Taking Birth Control? Y/N Planning Pregnancy? Y/N

Circle any of the following medical condition you have had:

Abnormal Bleeding	AIDS/HIV	Hepatitis A, B, C
Alcohol Abuse	Allergies	Anemia
Angina	Arthritis	Artificial heart/valves
Asthma	Back Problems	Bleeding w/ extraction
Cancer	Blood transfusion	Circulatory Problems
Colitis/IBS	Cortisone treatment	Congenital Heart Problems
Persistent cough	Diabetes	Difficulty Breathing
Drug Abuse	Emphysema	Epilepsy
Fainting/Dizziness	Fever Blisters	Glaucoma
Headaches	Heart Attack	Hemophilia
Jaundice	Jaw Pain	High/Low Blood Pressure
Kidney Disease	Liver Disease	Mitral Valve Prolapse
Behavioral Problems	Pacemaker/Defib	Nervous/Anxiety/Depression
Pneumonia	Psychiatric care	Radiation Treatment
Respiratory Disease	Rheumatic fever	Rheumatic Heart Disease
Scarlet Fever	Seizures	Swelling feet/ankles _____
Shingles	Sinus Problems	Swollen neck glands
Skin Rash	Stroke	Thyroid Problems Low/High
Tuberculosis	Tumors/growths	Venereal Disease
Ulcers	Facial Pain	Sleep Apnea/Snoring

Do you wear contacts or glasses? Yes/No

Have you ever been advised to take a pre-medication before dental treatment? Y/N

Have you been tested for HPV? Y/N Have you tested positive? Y/N

Do you use any of the following? Circle all that apply:

Cigarettes or Cigars	How many per day? _____	How many years? _____	
Smokeless tobacco	Marijuana	Cocaine or derivatives	
Vaping	Barbituates	Sleeping Pills	Opiates
Narcotic Pain Killers	Others: _____		

Please indicate your frequency of drug use and whether you inhale or inject:

_____

How many alcoholic drinks do you consume daily? _____

Do you drink grapefruit juice? Yes No

Do you have family history of any of the following?

Stroke	High Blood Pressure	Diabetes	Alzheimer's
Gastro Issues	Heart Attack	Thyroid	Heart Disease

Have you experienced any of the following problems?

Bleeding Gums	Grinding Teeth	Mouth Pain	Broken Denture
Swollen Gums	Lost/Loose Teeth	Sensitivity	Broken Teeth
Decay/Cavities	Lost Fillings	Bad Breath	Missing Teeth
Easily Gag	Bad Tastes	Food Stuck	Problems Chewing

Epworth Sleepiness Scale Form

Instructions: Be as truthful as possible. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box. A score of 10 or greater indicates a possible sleep disorder.

Situation	Responses	Score
Sitting and Reading	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Watching Television	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Sitting inactive in a public place, for example, a theater or meeting	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
As a passenger in a car for an hour without a break	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Lying down to rest in the afternoon	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Sitting and talking to someone	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
In a car while stopped in traffic	0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Total Score		

Please tell us about your comfort level with dental care. Check One:

___ I am completely comfortable ___ I am a little nervous when visiting
___ I try to avoid dental care ___ I am extremely phobic about dental care

Are you interested in sedation dentistry for your dental care? Yes No

Reason for today's visit: _____
What is your motivation for making this appointment? _____
What is your primary concern? _____

Please circle all that is important to you when making your dental health decisions:

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of Care
Technology	Health	What Insurance Covers
Comfort	Fear or Anxiety	Detailed Treatment Explanation

Would you like information about a Free Consult for any of the following services?

[Y] [N] Botox/Fillers [Y] [N] Clear Braces [Y] [N] Veneers/Cosmetics
[Y] [N] Whitening [Y] [N] Dentures [Y] [N] Implants

How often do you brush your teeth a day? □**0** □ **1** □**2** □**3**
What type of toothbrush do you use? □Manual □Electric _____ (Brand)
Is your manual brush bristle: □Soft □Medium □Hard
How many times do you floss each day? □**0** □**1** □**2** □**3+**

How many sodas, tea, coffee, Gatorade, etc. do you consume a day?
1-2 3-4 5-7 7+

Multiple screenings will take place during your visits here at our office such as:

-Risk Assessment- Evaluation of your dental and medical history, and blood pressure.
-Oral Cancer Screening -Occlusal Screening -Airway Screening
-Restorative Screening- Checking completed dentistry and health of the teeth
-Periodontal Screening- Examine the health of your gums and risk of boneloss

-Complimentary WiFi is available for your use throughout the office. Please feel free to bring your wireless internet device with you each visit.
- Blankets are available to keep you warm and relaxed during each visit
-Memory foam neck pillows are available as well as eye masks.

Is there anything we can do to make your visit more comfortable?

_____
_____

Please review the following policies, and initial on each short line.

Scheduling Policy

-For reservations longer than 60 minutes a deposit may be required upon scheduling. Financial arrangements will be discussed prior to scheduling initial treatment, and we encourage patients to be sure to understand treatment cost when scheduling. You may request a copy of the many financial options we are able to offer at any time. _____

-If you are unable to keep your reserved time with your doctor, we require 48 hour notice for schedule changes. This will allow time for another patient to take advantage of the doctor's time. Loss of deposit or broken appointment fee may occur without the proper notice given. _____

-We understand the need for families to attend appointments together, and do our best to coordinate request. As we will need to reserve a larger amount of time for family members, we cannot reschedule multiple visits together if previous appointments have been broken. A deposit may be required to reserve times for multiple family members. _____

-Our office primarily utilizes digital communication methods to confirm appointments. You may be contacted by text, email, phone, or mail. If you have a contact preference, please advise our scheduling coordinator. _____

-You will receive an invitation by text or email to provide your feedback about your experience in our office. We highly value all feedback so please take a moment to share a response. _____

Records

-We are required by law to maintain all records for our patients and therefore cannot release originals of any x-rays or chart materials. Written consent must be obtained by the patient or guardian prior to the release or transfer of any records. Duplication charges are applicable if copies are requested, and all fees must be paid prior to the release of materials. Digital copies are available upon request without charge. Please allow up to 72 hours for processing of record request. _____

Exposure Control

-In the event an employee suffers an exposure during your dental treatment, you consent to have blood drawn to provide pertinent medical information for the employee involved. All medical information is kept confidential and will only be provided by the physician to the employee involved as well as you. _____

-Due to costs of maintaining excellent infection control guidelines, our office institutes a five dollar infection control fee for each visit in our office. _____

Financial Policy

-We accept Cash, Money Orders, Visa, MasterCard, American Express, and Discover. Personal check payments will only be accepted for advanced prepayments of treatment scheduled a minimum of 2 weeks out. All checks must clear prior to the start of treatment. All check writers must have a physical address, and not a P.O. Box. A valid photo ID with correct address must be provided. Business checks are not acceptable. _____

-Payment is due at the time of service, and is understood to be an estimate from your insurance, and additional balance may be due once your insurance has made their payment decision. _____

-We request a credit card be provided to assist in making future reservation deposits, collection of balances in an agreed time frame, and reimbursements of credits. A form will be completed with your signature at the time financial arrangements are made, and kept on file. _____

-All treatment costs is an ESTIMATE provided by your insurance company. The information provided to us by the insurance company is not guarantee payment, and actual payment may differ. Insurance companies have a wide variety of plan limitations and exclusions that our office will not be aware of which can result in patient being financially responsible if the insurance company provides a lesser contribution than estimated. All charges you incur are your responsibility regardless of the insurance coverage. It is the patient's responsibility to become familiar with member status, benefits/eligibility, member status, and limitations of their dental plan. All treatment fees estimated are valid for 60 days.
_____

-EOB's are provided to patients from the insurance companies, and acts as a billing statement as it reflects the patients responsibility. Once our office receives a payment from your insurance company, a billing statement will be mailed reflecting any payment due. The payment due date will be shown on the statement, and if the balance is left outstanding, collection actions will proceed. _____

-Any unpaid balances is the patients responsibility, and collection action will proceed against outstanding balances as early as 45 days. You agree to reimburse us the fees of any collection agency, which may be based on a percentage of a maximum of 35% of the debt, all costs, and expenses, including reasonable attorney's fees we incur in such collection efforts. _____

-Your Social Security Number is required for billing and insurance purposes. If a SSN is unable to be provided, payment in full will be requested, and we will assist you in seeking reimbursement you're your insurance company. _____

Dental Insurance and Claim filing

-Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. The insurance relationship is between you and the employer. _____

-As a courtesy to you we will help you process your dental insurance claims. It is your responsibility to be sure your plan is active at the time of service, and coverage is available.

-Once an insurance claim is filed, 30 days is given for response and payment from the insurance company. If payment is denied from the insurance company, an appeal on your behalf will be filed if necessary. If a claim remains outstanding with no payment after 60 days, the balance will then be patient responsibility. Once a balance is paid, we will assist you in seeking reimbursement from your insurance. Any outstanding balance of 45 days or more is eligible for further collection action. _____

Primary and Secondary Insurances

-Once insurance information is verified by our office, we are obligated to file primary insurance first and secondary insurance last. It is not a patient's choice to select which company acts as primary and which acts as secondary. The insurances deem who is primary according to effective dates. _____

-Your treatment estimate will be based off of your primary insurance, and co-pays collected are according to your primary insurance. Claims are first sent to your primary insurance, and once patient responsibility indicated by the primary has been met, you secondary insurance will be sent a claim. We will submit to your secondary requesting you be reimbursed any portion the secondary plan contributes. In most cases, the secondary company requires proof of primary payment or denial before processing claims. Proper claim filing order will need to proceed to ensure timely payment from your insurance company. Any delay or failure to supply correct information which results in delayed payment will result in patient responsibility from patient. _____

HIPPA Release:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. The information may be released to:

_____

Indicate relationship to this person: _____
This will remain in effect until terminated by me in writing.

I attest that the above information I have provided is accurate and true to the best of my knowledge. I have answered all of the questions honestly and completely. I understand the doctor is basing his treatment and medications administered based on information provided.

I understand and accept the financial, scheduling, insurance, and office policies listed above. I agree to pay for all treatment in a timely fashion as described to avoid any additional fees. I hereby authorize the release of pertinent medical/dental information to my insurance carrier to facilitate claim filing on my behalf. This order remains in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ ____/____/____
Signature of Patient or Guardian Date

_____
Print Name