Frederick Dental Group ~ Registration and Health History

Patient Information: Please Call Me: _____*(Nickname)*

Name: _____ DOB ____/____/____

Address: _____

City/State/Zip_____ _____

*SSN: _____-_____-_____ Sex: M / F Height _____ Weight _____lbs

Home Phone _____-_____-_____ Cell Phone _____-_____-_____

Email Address : _____

➢ > ***SINGLE*** ***MARRIED*** ***DIVORCED*** ***SEPARATED*** ***WIDOWED*** <<

Employer: _____

Occupation: _____ Full Time or Part Time

How did you hear of our office? _____

If Google, what did you search to find us? _____

Preferred Method of Contact:
We send Newsletters, appt reminders, and other useful information

__ Home __ Cell __ Email

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Emergency Contact NAME: _____

Emergency Contact NUMBER: _____-_____-_____

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.

_____ _____ _____

_____ _____ _____

_____ _____ _____

☐ I do **NOT** take any prescribed medications, over-the-counter medications, supplements or dietary supplements

❖ **Have you ever been advised to take a pre-medication before dental treatment? Y / N**
(*due to Joint replacements or Heart conditions)*

IF YES, please explain: _____

OVER ⇨
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ALLERGIES: *Circle All that apply* ◯ I have NO known allergies

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

CHECK any of the following medical condition you have had: ◯ **NONE of the Following**

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

Any-other conditions NOT indicated above? _____

- Do you wear contacts or glasses? Yes / No
- Have you ever been advised to take a pre-medication before dental treatment? Yes / No
- Have you been tested for HPV? Yes / No Have you tested positive? Yes / No

Do you use any of the following? CHECK 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 Other: _____

How many alcoholic drinks do you consume daily? _____

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

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

- 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+

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 primary concern? _____

Please CHECK 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

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 else we can do to make your visit more comfortable?

OVER

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 REVIEW THE FOLLOWING POLICIES:

INITIAL on each line that you read and understand

SCHEDULING

_____- If you are unable to keep your reserved time with your doctor, we require **48 business hours** notice for schedule changes. This will allow time for another patient to take advantage of the doctor's time. Loss of deposit, late notice fee, or inability to reappoint may occur if the proper notice is not 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, you will need to give **72 business hours** notice to change reservations. Also, please note, we cannot reschedule multiple visits together on the same day if previous appointments have been broken or not given proper notice. A deposit may be required to reserve times for multiple family members. You may be requested to make a deposit for multiple family members.

_____- A reservation deposit that is applied to your treatment costs will be required when booking procedure time with our providers. Financial arrangements are offered prior to scheduling future treatment, and we encourage patients to be sure to understand procedure cost when scheduling. You may request a copy of the many financial options we are able to offer at any time.

_____- When time is booked for you on our schedule, future confirmation via text or call is required so our doctors and team know to expect you. Not responding to confirmation will risk removal from the schedule.

_____- Please understand the schedule is a living document that can change based on our patients needs or emergencies. There are times you may be notified that your check in time has been modified and if those changes are ever something that cannot be done for us you can simply communicate that to us. Our doctors do appreciate your understanding so they can serve our patients and community the best we are able to.

_____- 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, 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 to a patient. Digital copies of x-rays are released without charge. Charges are applicable if the information requested falls outside of digital x-ray release, and all fees must be paid prior to the release of materials. Please allow up to 72 hours for processing of record request.

_____- Records for patients are often exchanged with other dental or medical providers, health institutions, insurance companies, etc. as support of patient care. If there would be any restrictions of a specific doctor or organization you would not want your information supplied to, it is your responsibility to advise our office of that request.

_____- If at any time you wish to be inactivated and transfer elsewhere as a patient, payment of account balances are due to complete the inactivation of your account.

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.

OVER

FINANCIAL

_____- Payment is due at the time of service. We accept Cash, Money Orders, Visa, MasterCard, American Express, and Discover. Personal check payments will only be accepted for 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, not a P.O. Box. A valid photo ID with correct address must be provided. Business checks are not acceptable.

_____- You acknowledge and understand that the information provided to us by the insurance company was supplied with their disclaimer that it is "not a guarantee of payment, and the actual payment may differ." All treatment costs are an ESTIMATE provided by your insurance company, and additional balances due after insurance payment or denial will be reflected on a billing statement sent to you by our office. Our office is not responsible for insurance decisions. Personal information changes for accurate billing address information is patient responsibility.

_____- Insurance companies have a wide variety of plan limitations, exclusions, downgrades, deductibles, alternate benefits, and non-covered services that our office will not be aware of which can result in patient being financially responsible for services provided if the insurance company provides a lesser payment than they 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, and limitations of their dental plan.

_____- Our office cannot predict, guarantee, or promise what the final decisions your insurance company will make. Once a service is provided, the claim is filed to your insurance company, and we will then follow the information dictated by your insurance EOB response.

_____- Our office institutes a $10 fee for each visit in our office that is not billable to insurance.

_____- Treatment diagnosed and prescribed by the doctors will be provided as a written treatment plan and signature requested for chart documentation. Not all treatment plans are presented same day and a future treatment plan presentation would be scheduled for you. All treatment fees estimated are valid for 60 days.

_____- Any unpaid balance is the patient's responsibility; collection action will be taken against outstanding balances as early as 45 days of the date of service. 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 the patient/guardian's Social Security Number are unable to be provided, payment in full will be requested, and we will assist you in seeking reimbursement from 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 file your dental insurance claim. 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 requested by your insurance company to process. If payment is denied from the insurance company, an appeal on your behalf will be filed if necessary. You may be required to contact your insurance company to assist our office in obtaining payment on your behalf.

_____- If a claim remains outstanding with no payment after 60 days, it is possible the balance will then be the patient/guardian's responsibility. Our office would assist you in seeking reimbursement from your insurance.

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 your primary insurance, and co-pays collected are according to your primary insurance. Claims are first sent to your primary insurance, once the patient responsibility has been indicated by the primary, your 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:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

☐ **I do NOT authorize Frederick Dental Group to release information on my behalf**

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 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