

# CLARKSBURG DENTAL CENTER, LLC

23212 Brewers Tavern Way  
Clarksburg, MD 20871

## PLEASE TAKE A MOMENT TO READ OUR PAYMENT AND INSURANCE POLICIES

- As a COURTESY to our patients, Clarksburg Dental Center submits the necessary insurance paperwork for our patients at no charge. However, we have no control of and are not responsible for how your insurance company handles its claims or what benefits they pay on a claim.
- I agree to pay for all the services rendered on my behalf and/or my dependents at the time of service.
- I understand that insurance benefits are ESTIMATES ONLY based upon the information available to the provider by my insurance carrier. Eligibility is NOT a guarantee of payment, benefits are determined only when a claim is processed. Once the claim has been processed, any difference will be due upon receipt of a statement.
- I understand that any unpaid insurance claims or any balances that extend beyond 30 days will be assessed a service charge of 1.5% or a \$20.00 late fee per month, whichever is greater. In the event that this balance should be submitted to collection agency, a fee of \$50.00 will be charged to the account. If these fees should be added to my account, I will be notified by mail. Fees are subject to change, in the event of a fee change the responsible party or patient will be notified.
- A \$20.00 charge will be applied to the account for each returned check and/or declined credit card transaction.
- We reserve time in our office for you and your family to receive care. Should you need to cancel or re-schedule any appointments, please let us know at least 48 hours in advance. If an appointment is broken without advance notice, a \$30.00 broken appointment fee will be assessed per every half hour. This fee will become due as a part of your account balance, and it will need to be satisfied prior to scheduling future appointments. If a patient accumulates a total of (3) three failed, missed and/or cancelled appointments without proper notice. Future appointments may not be re-scheduled and we'll ask such patient to seek services at another dental practice.
- I HAVE READ THE ABOVE POLICIES, AGREE TO THEM, AND HAVE HAD THE OPPORTUNITY TO HAVE ALL MY QUESTIONS ANSWERED.

Signature of patient, parent, or guardian (seal): \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please Print Patient's Full Name: \_\_\_\_\_

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## HIPAA CONSENT

I understand that I have the right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carryout:

- Treatment (including direct or indirect treatment by other healthcare providers involving in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operation of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected healthcare information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signature of patient, parent, or guardian (seal): \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please Print Patient's Full Name: \_\_\_\_\_

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Shingles
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
				<input type="checkbox"/> Venereal Disease
				<input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



# Welcome to Clarksburg Dental Center

23212 Brewers Tavern Way

Clarksburg, MD 20871

301.515.5525

[www.clarksburgdentalcenter.com](http://www.clarksburgdentalcenter.com)

## PATIENT INFORMATION

FULL NAME \_\_\_\_\_  
(FIRST) (MIDDLE INITIAL) (LAST NAME)

PREFERRED NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_ GENDER  MALE  FEMALE

MARITAL STATUS  MINOR  MARRIED  DIVORCED  SEPARATED  WIDOWED

ADDRESS \_\_\_\_\_  
(STREET)

\_\_\_\_\_  
(CITY) (STATE) (ZIP)

PHONE NUMBERS H \_\_\_\_\_ C \_\_\_\_\_ W \_\_\_\_\_

LICENSE NUMBER \_\_\_\_\_ E-MAIL \_\_\_\_\_

\*\*\*MAY WE CONTACT YOU FOR UPCOMING APPOINTMENTS, RECALL REMINDERS, NEWSLETTERS,  
AND FOLLOW UPS VIA (PLEASE CHECK ONE)  E-MAIL  TEXT MESSAGE OR  BOTH

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

STUDENT  FULL TIME  PART TIME NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## RESPONSIBLE PARTY

FULL NAME \_\_\_\_\_  
(FIRST) (MIDDLE INITIAL) (LAST NAME)

RELATIONSHIP TO PATIENT \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER  MALE  FEMALE

ADDRESS (IF DIFFERENT) \_\_\_\_\_  
(STREET)

\_\_\_\_\_  
(CITY) (STATE) (ZIP)

PHONE NUMBERS H \_\_\_\_\_ C \_\_\_\_\_ W \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**EMERGENCY CONTACT**

NAME \_\_\_\_\_ RELATIONSHIP TO THE PATIENT \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

(STREET)

(CITY)

(STATE)

(ZIP)

PHONE NUMBERS H \_\_\_\_\_ C \_\_\_\_\_ W \_\_\_\_\_

**INSURANCE**

**PRIMARY INSURANCE**

SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SUBSCRIBER'S BIRTH DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_ - \_\_\_\_ - \_\_\_\_

EMPLOYER \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

MEMBER ID \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**SECONDRARY** (IF APPLY, PLEASE COMPLETE FOLLOWING)

SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SUBSCRIBER'S BIRTH DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_ - \_\_\_\_ - \_\_\_\_

EMPLOYER \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

MEMBER ID \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**DENTAL HISTORY**

WHAT IS THE PURPOSE OF TODAY'S VISIT \_\_\_\_\_

WHEN WAS YOU LAST EXAM AND CLEANING \_\_\_\_\_ X-RAYS \_\_\_\_\_

**DID YOU HAVE ANY OF FOLLOWING PROCEDURES**

- SCALING AND ROOT PLANNING (DEEP CLEANING)
- CROWN / BRIDGES
- SEALANTS
- EXTRACTION

IF YES, WHEN \_\_\_\_\_



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### REFERRAL

PATIENT'S FULL NAME: \_\_\_\_\_

#### WHO MAY WE THANK FOR REFFERING YOU?

- DOCTOR**                      NAME OF THE OFFICE \_\_\_\_\_
- EXISTING PATIENT**    NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
- FLYER / MAILER**
- INTERNET**
- INSURANCE**
- OTHER**                      PLEASE SPECIFY \_\_\_\_\_