

# Welcome to Beltsville Dental Care

## Patient Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ City, State, & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Gender \_\_\_\_\_ E-mail \_\_\_\_\_

Referred By: \_\_\_\_\_ ( Please ask about our Care Enough to Share Program )

## Responsible Party Information

Name of Responsible Party \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

How would you like to pay for your portion of the provided services? Cash [ ] Check [ ] Credit Card [ ]

## Dental Insurance

Insurance Company \_\_\_\_\_ Insured Name \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_

## Secondary Dental Insurance

Insurance Company \_\_\_\_\_ Insured Name \_\_\_\_\_

Insured DOB \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_

## Patient Dental History

Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last full mouth x-rays \_\_\_\_\_

Do you require medication prior to Dental Treatment?  Yes  No

Which of these dental-aids do you use? Sonicare  Braun  Toothpicks  Bleach Kits  Floss

Do you clench or grind your teeth? Yes  No  Do you wear a Night Guard? Yes  No

Do you have active dental problems now? Gum Disease  Bleeding Gums  Broken Teeth  Decay

Have you ever had gum surgery? Yes  No

**Patient Medical History**

Please check the conditions listed below that apply to you.

- AIDS
- Allergies \_\_\_\_\_  
(Hayfever ) \_\_\_\_\_
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Excessive Bleeding
- Fainting
- Glaucoma
- HIV
- Head Injuries
- Heart Disease, Heart Attack
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Liver Disease
- Mental Disorders
- Pacemaker
- Pregnancy
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Kidney Disease
- Stroke
- Tuberculosis
- Ulcers
- STDS
- Codeine Allergy
- Penicillin Allergy
- Other: \_\_\_\_\_
- Stomach Problems
- Epilepsy

Have you ever taken any Medication for Osteoporosis? ( Fosamax, Zometa, Aredia,or Actonel )     Yes     No

Have you had any complications due to Dental Treatment?     Yes     No  
If yes please explain \_\_\_\_\_

Have you been admitted to a Hospital or needed emergency care during the past two years?     Yes     No  
If yes please explain \_\_\_\_\_

Are you under a physicians care now?     Yes     No    Name of family Physician \_\_\_\_\_

Do you have any health problems that need further clarification? \_\_\_\_\_

Please list all medications that you are currently taking \_\_\_\_\_

**Financial Agreement**

This office participates with CareFirst, Delta Dental, and Denta Quest Choice. Patients who carry dental insurance understand that all services furnished are charged directly to the patient and that he or she is personally responsible for payment for all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance. We offer a 5% discount to our patients who pay their treatment plans up front in full.

A service charge of 1 ½ % per month ( 18% per annum ) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If the account is not cleared, the account will be turned over to collections and a 30% collection fee will be added.

Any checks returned to the office are subject to an additional fee of \$25.00.  
If for any reason you are unable to keep your appointment, 24 hours notice must be given to avoid the \$40.00 broken appointment fee.

I have read the above conditions of treatment and payment and agree to their content. All the above answers and information provided are true and correct. If I have any change in my health I will notify the doctors on my next appointment.

\_\_\_\_\_  
Signature of patient, parent, or guardian    Date \_\_\_\_\_    Relationship to patient \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment    Date \_\_\_\_\_    Relationship to patient \_\_\_\_\_