

PATIENT INFORMATION

Email _____ SSN: _____ - _____ - _____

Name: _____ Mobile Phone _____
Last First MI

Address: _____ Apt _____ Home Phone _____
City State Zip

Work Phone _____

Birthdate: ____/____/____ Age _____ Sex _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Child

Driver's License Number _____ State _____ Employer: _____

In case of emergency, contact: _____ Relation: _____ Phone _____
Full Name of Contact

Are any of your family members patients of this practice? ☐ Yes ☐ No Name(s) and relation: _____

REFERRAL INFORMATION Who may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION: (who is responsible for paying any balance?)

☐ **SELF** *same as Patient information (18 yrs old+)

Name: _____ SSN _____ - _____ - _____
Last First MI

Address: _____ Apt _____ Relationship to Patient _____
City State Zip

Best contact () _____

Birth date: _____ Email _____ Driver's License # _____ State _____

INSURANCE INFORMATION: ☐ INSURANCE CARD PROVIDED

PRIMARY Insurance Plan Name & Address: _____ Phone Number: _____

Policy Holder: _____ Birthdate: _____ SSN: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder's Address: _____ Phone Number: _____
Street City State Zip Code

Policy Holder's Employer: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY Insurance Plan Name & Address: _____ Phone Number: _____

Policy Holder: _____ Birthdate: _____ SSN: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder's Address: _____ Phone Number: _____
Street City State Zip Code

Policy Holder's Employer: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

INSURANCE RELEASE AUTHORIZATIONS AND ASSIGNMENT

I certify that the information pertaining to my active dental insurance coverage is correct and I am responsible for updating my dental insurance should any changes occur.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes Glen Burnie Dental Group to submit insurance claim forms and receive payment directly from my insurance carrier with the notation "Signature on File".

I authorize my Dentist(s) to release treatment records, x-rays and any other information deemed pertinent to my insurance carrier as necessary or requested.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental insurance.

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out activities in connection with any claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Glen Burnie Dental Group or treating dentist.

X

Patient / Responsible Party and Subscriber Signature

Date

PATIENT CONSENT

During your initial visit, a comprehensive examination will be conducted to assess your dental health. X-rays and other diagnostic tools may be used to formulate an accurate treatment plan.

- I (Patient/Responsible party) authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my (or my dependent) dental needs.
- Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

X

Patient or Responsible Party Signature

Date

Turn page

DENTAL HISTORY

What is the REASON for this appointment? _____

How often do you brush & Floss? _____

When was your LAST dental appointment? _____

What was your LAST dental appointment for? _____

When was your LAST dental cleaning? _____

Date of LAST Dental Xrays? _____

How would you like to improve your smile? _____

Have you had problems with previous dental treatment? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Have you been told that you have gum disease? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Do you have difficulty chewing your food? ☐ Yes ☐ No

Are your teeth sensitive to hot foods/liquids? ☐ Yes ☐ No

Are your teeth sensitive to cold foods/liquids? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you suffer from pain in your jaw? ☐ Yes ☐ No

Do you take fluoride supplements? ☐ Yes ☐ No

MEDICAL HISTORY:

Yes No Date of last Physical medical exam: _____

☐ ☐ Currently under the care of a physician?

MEDICAL PHYSICIAN : _____ Phone: _____
Name

☐ ☐ Have you been hospitalized in the past 5 years?

-If yes, for what reason? _____

Please answer YES or NO to the following health conditions:

Yes No

☐ ☐ Cardiovascular disease

☐ ☐ Angina

☐ ☐ Arteriosclerosis

☐ ☐ Artificial heart valve

☐ ☐ Congenital heart disease

☐ ☐ Congestive Heart Failure

☐ ☐ Heart attack

☐ ☐ Heart murmur

☐ ☐ Low blood pressure

☐ ☐ High blood pressure

☐ ☐ High Cholesterol

☐ ☐ Mitral Valve Prolapse

☐ ☐ Pacemaker

☐ ☐ Rheumatic Fever

☐ ☐ Anemia

☐ ☐ Blood transfusion

☐ ☐ Hemophilia

☐ ☐ AIDS or HIV infection

☐ ☐ STD _____

☐ ☐ Autoimmune Disease

☐ ☐ Arthritis

☐ ☐ Rheumatoid Arthritis

☐ ☐ Asthma

☐ ☐ Herpes

Yes No

☐ ☐ Emphysema

☐ ☐ Sinus trouble

☐ ☐ Tuberculosis

☐ ☐ Cancer

☐ ☐ Radiation Therapy

☐ ☐ Chemotherapy

☐ ☐ Diabetes type I

☐ ☐ Diabetes type II

☐ ☐ Claustrophobia

☐ ☐ Acid reflux (GERD)

☐ ☐ Hypothyroidism

☐ ☐ Hyperthyroidism

☐ ☐ Stroke

☐ ☐ Glaucoma

☐ ☐ Hepatitis A/B

☐ ☐ Hepatitis C/D/E

☐ ☐ Epilepsy

☐ ☐ Seizures

☐ ☐ Alzheimer's

☐ ☐ Dementia

☐ ☐ Osteoporosis

☐ ☐ Joint replacement

☐ ☐ Bronchitis

☐ ☐ Cold Sores

Yes No

☐ ☐ Depression

☐ ☐ Anxiety

☐ ☐ Alcoholism

☐ ☐ Drug abuse/addiction

☐ ☐ Smoking

☐ ☐ Mental Disorder _____

☐ ☐ Mental Disability _____

Yes No

☐ ☐ Aspirin

☐ ☐ Penicillin / Amoxicillin

☐ ☐ Clindamycin

☐ ☐ Erythromycin

☐ ☐ Sulfa drugs

☐ ☐ Latex

☐ ☐ OTHER: _____

ALLERGIES:

WOMEN ONLY:

Yes No

☐ ☐ Taking contraceptives (birth control)

☐ ☐ **PREGNANT Now (make front desk aware)**

If yes, DUE DATE _____

☐ ☐ Have you been Pregnant within the past 6 months?

Date _____

☐ ☐ Nursing

Other condition(s) or problem (s) not listed above? _____

Add anything else you would like us to know. _____

*****CURRENT MEDICATIONS:** _____

Has a separate paper list of MEDICATION been provided to staff? ☐ No ☐ Yes, I have provided the office with a list of all medications and supplements that I am currently taking.

Are you taking/have you taken **BISPHOSPONATE**? _____ Any **BLOOD THINNER**? _____

Over the counter supplements: _____

PHARMACY: _____ Phone: _____

Name

Address

I have completed the form to the best of my understanding. I acknowledge that any subsequent changes are my responsibility, and I commit to providing written updates in regards to my insurance or my health to the dental practice during my upcoming dental appointment.

X

Patient / Responsible Party Signature

Date

Thank you for choosing Glen Burnie Dental Group, where your oral health is our utmost priority. Our mission is to provide you with the highest standard of care, ensuring you achieve optimal oral health and a confident smile. As part of our commitment to excellence, we want to familiarize you with our dental office policies and financial obligations. These guidelines are designed to support your well-being and ensure a seamless experience with us.

DENTAL APPOINTMENT POLICY

In our dental practice, we have implemented a strict appointment policy to ensure efficient scheduling and provide optimal care for our patients. By adhering to our dental appointment policy, you greatly contribute to maintaining an efficient schedule and ensuring the highest level of care for all our patients. We sincerely appreciate your understanding and cooperation in this matter. Below are the specifics of our appointment policy:

Reminder Notifications - You will receive a confirmation request via phone call, text, and/or email 2-4 days before your reserved appointment. If the appointment reservation is not confirmed, a cancellation notification will be sent. To reschedule, contact our office within at least 24 hours via text or phone. By signing below, the patient acknowledges and consents to Glen Burnie Dental Group sending appointment reminders and other communications, via email, phone calls, and text messages. You can opt out of reminders in writing or by replying STOP to our reminder system.

Payment Policy - We value the time reserved for each patient's appointment. If a patient arrives without the required payment, a missed appointment fee will be applicable to reschedule the appointment. This fee is implemented to ensure fairness and uphold our commitment to efficient scheduling. Please take note of this policy and ensure you have the necessary payment at your appointment to avoid any inconvenience or additional fees. When scheduling your dental appointment, it is your responsibility to be aware of your out of pocket cost based on the estimated treatment case. Feel free to contact our office prior to the day of your appointment if you have any questions regarding the payment for your dental treatment.

Cancellation Notices - If you receive a cancellation notice due to a lack of confirmation on your part, this is your final opportunity to confirm. If no confirmation is received, the reserved appointment will be automatically cancelled. This ensures effective schedule management and helps us accommodate other patients in need of dental care.

Tardiness - We understand that unforeseen circumstances may cause a patient to arrive late for their dental appointment. Therefore, we allow a grace period of 10 minutes for tardiness. If patient arrives over the grace period limit, the appointment will be rescheduled and a fee may apply.

Missed/Short Notice - If a confirmed appointment is not attended or cancelled with less than 24 hours notice, a rescheduling fee will be applied at the time of rescheduling the appointment. Any not attended confirmed appointments for the Endodontist specialist a fee of \$100 applies.

Dismissal - If you have 2 confirmed appointments: missed, cancelled with less than 24 hours notice, or tardiness beyond grace period, within a year, you may be dismissed from our practice due to non-compliance with our appointment policy.

Minor Policy - For patients under the age of 18 or special needs patients, we kindly request that a parent, legal guardian, or authorized adult accompanies them to appointments. This accompanying guardian should be prepared to provide written consent for any dental procedures or treatments. Additionally, they are required to stay on the premises until the completion of the patient's dental treatment.

Medical Changes - Patients are requested to inform us of any medical changes, including (but not limited to) pregnancy, updated medication list, (ex: biphosphonate medications, need of pre-medication) and any other medical conditions, when scheduling an appointment. This is to ensure that we can provide the best possible care and make any necessary accommodations. In the case of pregnancy patients, we require an OBGYN dental clearance letter at the time of the appointment. These measures are in place to prioritize the safety and well-being of both the patient and their unborn child. If unable to provide us with the necessary medical updates your appointment may be rescheduled. We appreciate your cooperation in adhering to these policies to ensure a smooth and comprehensive healthcare experience.

DENTAL RECORDS POLICY

X-Rays from External Providers - In order to maintain insurance compliance and adhere to frequency limitations, patients must submit their dental records at least 24 hours prior to their dental appointment. Failure to do so will lead to the office conducting diagnostic procedures, including bitewings, panoramic, and/or full-mouth x-rays.

X-ray Requests From Our Office - For x-ray requests from our office, kindly provide a minimum of 48 hours to process. If you are requesting our office to send x-rays to another provider, please email us at office@glenburniedentalgroup.com. Include your full name, date of birth, and the email address to which you want us to send your records. Providing written consent via email ensures accurate transmission and compliance with HIPAA policies.

ZERO TOLERANCE POLICY

In order to ensure the successful provision of our services, it is essential to maintain a mutual respect between our staff and patients. Our team strives to be courteous, supportive, and considerate of each patient's unique needs and circumstances. However, any form of aggressive behavior, whether it be violent or abusive, will not be tolerated and may lead to dismissal from our practice.

In order for our office to maintain good relations with our patients, we would like to ask all of our patients to read and take note of types of behavior that will be found unacceptable:

- Verbal abuse, such as shouting, using foul language, or swearing
- Any form of physical violence directed at any staff member
- Persistent or unrealistic demands causing stress to the staff will not be tolerated. Requests will be accommodated whenever feasible, with explanations provided when they cannot be fulfilled.
- Causing damage or stealing from the practice's premises, staff, or patients.

DISCLOSURE OF PATIENT INFORMATION (HIPAA)

At your request, we may disclose your dental health information to a family member or other person listed below. We may disclose the following X-rays, referrals, prescriptions, release of dental/medical forms, clerical notes, lab scripts, insurance information, any treatment instructions, patient demographic, photo, and pharmacy information.

- I understand that I have to provide a written notice/update to change or revoke this authorization.
- Glen Burnie Dental group and employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I authorize the disclosure of my/my dependent's PHI (Protected Health Information) to:

Please list the names to which we may discuss your information.

Please Print Full Name of Authorized Person 1

Please Print Full Name of Authorized Person 2

FINANCIAL POLICY

Payment is due at the time services are rendered. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service.

Forms of payment (all patients) - We accept: cash, debit card, credit card (Visa, Master Card, Discover, and American Express), FSA flex spending account, HSA health savings account, and other third party financing options (Care Credit, Cherry, Sunbit and other). Please be advised that we do not accept personal checks as a form of payment.

Deposit Policy – In addition to diagnostic and preventive procedures, our office requires a deposit of at least \$100.00, or 20% of the treatment cost, to secure your dental treatment appointment. This deposit will be credited toward your out-of-pocket costs. Deposits are fully refundable if you cancel your appointment with at least 24 hours' notice. If the appointment is missed or canceled with less than 24 hours' notice (as per our appointment policy), the deposit will be applied toward a rescheduling fee.

Non-insured Accounts – are expected to make payment in full at the time services are rendered.

Insurance Accounts – Our office is in-network with a wide range of dental insurance plans.

- **Utilizing your Insurance** – Patient is responsible to provide our office with all insurance cards when reserving any dental appointment. In the event of enrolling in or changing insurance companies, we kindly request that you notify our practice at least 48 hours prior to your appointment. Our staff will contact the insurance for eligibility and benefit information. If insurance information is not provided within 48 hours, you will be expected to pay for services rendered.
- **Multiple Insurances** – Our office accepts and will bill a maximum of 2 insurance plans. Should patient have a tertiary insurance the patient will be responsible for submitting the claim and receiving payment.
- **Medicaid and Medicare Members** – these policies are billed as payer of last resort: by law, all other sources of coverage must pay claims under their policies before Medicaid or Medicare can be billed.
- **Insurance Company Benefits** - The insurance contract is an agreement between the Patient and the Insurance Company. Patients bear ultimate responsibility for all charges incurred during their visit to our practice, regardless of the payable benefits indicated by the insurance plan.
- **Insurance Payment** – The ultimate decision regarding payment will be determined by your insurance benefits provider during the claim processing. Submitting a claim to your insurance company for rendered services does not guarantee payment. Insurance benefits payable are contingent upon the insured's eligibility, plan limitations, exclusions (including pre-existing conditions, downgrades, missing tooth clause, waiting periods, annual maximum, other). In the event that your insurance has not paid for your account within 60 days, we reserve the right to discontinue or refuse to file a claim or appeal. The balance will become the responsible party's responsibility.
- **Office Treatment Case Estimation** - While we make efforts to provide estimated treatment case coverage information based on your plan benefit, our office does not guarantee payment from your insurance. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. Patients are encouraged to be aware of their insurance policy's limitations. In the event of underpayment, we will send you a statement. In the event of overpayment on your part, after claims are received you will be reimbursed at your request.
- **Out-of-Network Dental Members** - Patients who choose to receive dental services from out-of-network providers may be subject to different terms and conditions than those outlined in their in-network coverage. Out-of-network services may have different reimbursement rates, coverage limitations, and out-of-pocket expenses.
- **Credit Balances**
Any credit balance on a patient account must be requested by the patient within **12 months** of the credit being issued. After 12 months, any remaining credit balance will be written off and will no longer be available for refund.

Past Due Accounts - Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. A late fee may be charged on any account that is not paid within thirty (30) days of the statement date. By providing your mobile phone number, you consent to receive text (SMS) communications from Glen Burnie Dental Group regarding billing, account information, payment reminders, and other related matters. Standard message and data rates may apply.

Balances Over 90 days - Billed, accounts that are not paid within 90 days (or after 3 billing statements) may be referred to a collection agency. All reasonable expenses incurred in the collection process (including any collection expenses, court and attorney fees) will be the account holder's responsibility.

Collections - In the event that your account is turned to collections, the responsible party agrees for all collection fees in addition to the account principal balance including but not limited to reasonable attorney's fees and interest at the rate of 1.5% per month from the date of service until paid in full. Non-emergency treatment will not be provided until the outstanding balance is settled. By signing below, the (Patient / Responsible Party) understands and agrees that in the event of account default, to pay all reasonable collection charges and/or attorney fees.

If you have any questions regarding any aspect of our office policy, please feel free to present your question to any of our team members.
By signing below, I (Patient / Responsible Party) have read, understand and agree to be legally bound by the practice policies (pages 1 & 2).

X

Patient / Responsible Party Signature

Date