

PATIENT INFORMATION

SSN: _____ - _____ - _____ Birthdate: _____ / _____ / _____

Name: _____
Last First MI

Mobile Phone () _____
Are we authorized to leave messages on your mobile device? ☐ Yes ☐ No

Address: _____ Apt _____ Home Phone () _____

City: _____ State: _____ Zip _____ Work Phone () _____

EMAIL _____ Employer: _____

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

Are any of your family members patient's of this practice? : ☐ No ☐ Yes, Name(s) : _____

DENTAL INSURANCE: _____ POLICY# _____

POLICY HOLDER (Other than yourself) NAME: _____ DOB: _____

***LIST CURRENT MEDICATIONS:

Over the counter supplements: _____

MEDS LIST Provided? ☐ 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**? _____

Have you been hospitalized in the past 5 years? ☐ No ☐ Yes

-If yes, for **what reason**? _____

Preferred PHARMACY

Name Address Phone

Please answer **YES** or **NO** to the following health conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	Cardiovascular disease	☐	☐	Bronchitis	☐	☐	Depression
☐	☐	Angina	☐	☐	Emphysema	☐	☐	Anxiety
☐	☐	Arteriosclerosis	☐	☐	Sinus trouble	☐	☐	Alcoholism
☐	☐	Artificial heart valve	☐	☐	Tuberculosis	☐	☐	Drug abuse/addiction
☐	☐	Congenital heart disease	☐	☐	Cancer	☐	☐	Smoking
☐	☐	Congestive Heart Failure	☐	☐	Radiation Therapy	☐	☐	Mental Disorder _____
☐	☐	Heart attack	☐	☐	Chemotherapy	☐	☐	Mental Disability _____
☐	☐	Heart murmur	☐	☐	Diabetes type I	ALLERGIES:		Yes No
☐	☐	Low blood pressure	☐	☐	Diabetes type II			☐
☐	☐	High blood pressure	☐	☐	Claustrophobia	☐	☐	Penicillin
☐	☐	High Cholesterol	☐	☐	Acid reflux (GERD)	☐	☐	Amoxicillin
☐	☐	Mitral Valve Prolapse	☐	☐	Hypothyroidism	☐	☐	Clindamycin
☐	☐	Pacemaker	☐	☐	Hyperthyroidism	☐	☐	Erythromycin
☐	☐	Rheumatic Fever	☐	☐	Stroke	☐	☐	Sulfa drugs
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Latex
☐	☐	Blood transfusion	☐	☐	Hepatitis A/B	☐	☐	OTHER: _____
☐	☐	Hemophilia	☐	☐	Hepatitis C/D/E	WOMEN ONLY: Yes No		
☐	☐	AIDS	☐	☐	Epilepsy			
☐	☐	HIV infection	☐	☐	Seizures	☐	☐	Pregnant
☐	☐	Autoimmune Disease	☐	☐	Alzheimer's	If YES, DUE DATE _____		
☐	☐	Arthritis	☐	☐	Dementia	☐	☐	Nursing
☐	☐	Rheumatoid Arthritis	☐	☐	Osteoporosis	☐	☐	Taking contraceptives (birth control)
☐	☐	Asthma	☐	☐	Joint replacement			

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

I have filled out this Form to the best of my knowledge; I understand if there are any changes I am responsible for updating these changes with the dental practice.

PRINT Patient Name

SIGNATURE of Patient or Responsible Party

Date **TURN PAGE>>>>**



OFFICE POLICIES & CONSENT

Please fill out **ALL** information clearly and accurately

Disclosure of Patient Information (All Patients)

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, and 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 (All Members)

The following describes our Financial Policy. Our office is committed to providing you with the best possible care. Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our team members.

Payment for services is due at the time services are rendered. We accept cash, debit card, credit card, flex spending, HSA and other financing options such as Care Credit, Cherry, and SunBit. By providing your mobile phone number, you consent to receive text (SMS) communications regarding billing, account information, payment reminders, and other related matters. Standard message and data rates may apply. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service.

Deposit Policy:

For procedures which involve a major procedure we require a \$100 deposit to reserve your appointment. This deposit is credited toward your out of pocket cost. This deposit is kept to cover your missed appointment fee if you fail to cancel your appointment with less than **24 hours** notice. You will still be subject to our appointment policy for cancelling with less than **24 hours** notice.

Appointment Policy:

We will work hard to accommodate appointments that fit your schedule and dental needs. We ask that you let us know about changes **24 hours** in advance. We do understand that life happens, but **any missed appointment without 24 hours notice will be subject to a \$50 short/no notice fee. You must call our office to cancel any appointment that you cannot make it to.**

Dismissal Policy:

Two (2) missed appointments without 24 hours notice are grounds for dismissal from our practice.

X-ray Policy:

All x-ray requests require at least 48 hours notice. We will do our best to accommodate your needs in a timely manner.

Minor Policy

All **minor patients** must be accompanied by an adult (**parent or legal guardian**). The adult accompanying the minor is required to pay in accordance with our policies. We neither accept third party assignments nor do we recognize or enforce the terms of divorce or child support decrees.*

I have read and understand the Financial Policy and Appointment Policy for Glen Burnie Dental Group and I agree to abide by these policies.

PRINT Patient Name

SIGNATURE of Patient or Responsible Party

Date

Insurance Policy and Assignment of Benefits (Insured Members)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, it is your responsibility to make sure we have accurate and up to date insurance carrier information, restrictions of your policy, and billing information. If your insurance company has not paid your claim in full within 60 days the remaining balance will automatically become patient responsibility.

Services, which are not covered, downgraded or fall under L.E.A.T (least expensive alternate treatment) by your insurance are your responsibility. Any balance left unpaid after 30 days will be sent to collections, these accounts will accrue a \$35 delinquency fee in addition to any past due balance.

I hereby authorize my primary and/or secondary insurance company to make payments directly to Glen Burnie Dental Group. Furthermore, I have read and understand the Insurance Policy for Glen Burnie Dental Group. I agree to abide by these policies.
Patient/Guardian

PRINT Patient Name

SIGNATURE of Patient or Responsible Party

Date