Harford County Dentistry

General Information
Today's Date: _____
Name: (first, middle initial, last):_____
Sex (M/F):_____ Date of birth: _____
Social Security #:_____
Phone: (home):_____, (work): _____, (cell): _____
Email: _____
Address: _____
Referred by: _____
In case of emergency (name of contact and his/her telephone #): _____

*****Insurance*****
We are pleased that you have dental insurance and will be glad to assist you in obtaining the maximum benefits specified in your contract. You must realize that your benefit program is a contract between you, your employer (if applicable), and the insurance company. We are not party to that contract. We can generally give you an approximate estimate of your insurance benefit, but we are not responsible for any discrepancy between the estimated benefit and the actual payment. We must emphasize that as dental care providers, our relationship, is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

SIGN: _____DATE:_____

Person Responsible for Account (first, middle initial, last name): _____
Relation to Patient: _____ Date of birth: _____Social Security #: _____
Address if different from Patient's: _____
Phone if different from Patient's: (home):_____,(work):_____,(cell): _____
Person Responsible Employed by: _____
Business Phone: _____
Insurance Company: _____

Insurance Company address (please include all addresses provided on card):
_____
_____
_____
Subscriber ID #: _____ Group #: _____
Names of other dependents covered on this plan: _____

Is the patient covered by additional insurance: (Y/N): ____; (if no skip to Assignment of Benefits)
Person Responsible for Account (first, middle initial, last): name):_____
Relation to Patient: _____ Birth date: _____ Social Security #:_____
Address if different from Patients: _____
Phone if different from Patient's: (home) _____(work)_____(cell) _____
Person Responsible Employed by: _____
Business Phone: _____
Insurance Company: _____

Insurance Company address (please include all addresses provided on card):
_____
_____
_____
Subscriber ID #: _____Group #:_____
Names of other dependents covered on this plan:
_____

Assignment of Benefits
The undersigned hereby releases payment directly to Harford County Dentistry of the group insurance benefits otherwise payable to the undersigned but not to exceed the actual charges for the covered services. The undersigned agrees to be financially responsible for any charges not covered by the insurance benefits.

Signed: _____Date: _____

Responsibility and Consent
I give my consent to any advisable and necessary dental procedures, medications, and/or anesthetics to be administered by Harford County Dentistry.
Signature of Patient (if over the age of 18) and date: _____

Signature of Parent, Guardian or Personal Representative (if under 18) and date:

_____Date: _____

Harford County Dentistry

Cancellation Policy

Harford County Dentistry is committed to providing all of our patients with exceptional care. Unfortunately when a patient cancels without giving notice, they prevent another patient from being seen. Please call us at (410)877-7900 **within 24 hours** of your scheduled appointment start time to notify us of any changes or cancellations. **To cancel a Monday appointment, please call our office by 12:00 p.m. on Thursday.** If prior notification as stated above is not given, you will be charged **$50.00** for the missed appointment.

Please sign below to consent to these terms:

_____

Patient's Parent/ Guardian if under 18:

_____

Date:_____

Harford County Dentistry

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Harford County Dentistry Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____ _____

Patient Name Date

_____

Signature

Medical History Review (past and present)

Cardiovascular

- Heart Attack: Date:_____
- Heart Surgery: Date: _____
- Congestive Heart Failure
- Blood pressure Problems: High / Low
- Heart Palpitations / Arrhythmias / Irregular beat
- Implanted Devices-pace maker /defibrillator
- Artificial or valvular disease/ Congenital Heart Disease
- Chest Pain / Angina
- Endocarditis

Pulmonary

- Lung Disease/ Short of Breath / persistent cough
- Asthma / Emphysema / COPD
- Tuberculosis (Self or Family Member)
- Pneumonia / Bronchitis

Central Nervous System

- Epilepsy / Seizure Frequency of attacks: _____
- Stroke / Transient ischemic attacks Date: _____
- Neuralgia / numbness / tingling / headaches
- Nervous or psychological problems
  (Anxiety / Depression / Schizophrenia / Bipolar)

Hematologic

- Sickle Cell Anemia (trait or disease) Last attack date:_____
- Other anemia's (pernicious / iron deficiency)
- Excessive or abnormal bleeding / bruise easily
- Hemophilia
- Blood Transfusion from 1977-1985 (self/sexual partner)
- Do you take anticoagulants/ blood thinners
  (Aspirin / Plavix / Coumadin / Ticlid / Aggrenox)

GI

- Ulcer/ GERD/ bowel or rectal problems
- Liver Disease / Cirrhosis
- Hepatitis (self or family) Type _____
  Treatment: _____

GU

- Kidney or Bladder Disease
- Dialysis: Tx Days : _____
- Sexually transmitted disease
  (Syphilis / gonorrhea / other venereal disease)
- HIV/AIDS (self or sexual partner)

Endocrine

- Diabetes (controlled by diet / oral meds / insulin)
  Blood glucose _____ / HbA1C _____
- Thyroid Disease (hyper / hypo)
- Other gland disease (adrenal / pituitary / prostate)

Woman Only

- Is there a possibility you're pregnant? YES / NO
- Nursing
- Are you taking birth control pills? YES / NO

Musculoskeletal

- Arthritis / painful joints / rheumatism
- Artificial joints Date: _____
- Osteoporosis
- Biphosphonates (P.O. / I.V.)
  Start Date: _____

ENT

- Ear / Eye / Nose / Sinus Problems
- Unexplained or persistent swollen nodes or glands

Dermatological /Immunologic

- Skin rash / Hives
- Autoimmune disease (e.g. Lupus / RA / CT Disorder)

Surgery/Hospitalization/Other Illness

- Operations/Hospitalization Date and Reason
  _____
  _____
  _____
- Cancer or tumor Location: _____ Date: _____
  Treatment (Surgery / Chemotherapy / Radiation)
- Organ Transplant: Type: _____ Date: _____
- Other condition _____
- When was your last medical visit? _____
  Why? _____
  Date of last blood work? _____ Reason _____

Social

- Tobacco use (cigarettes/E-cig / cigars / chewing tobacco /snuff)
- Past or present alcohol abuse? Drinks per day _____
- Past or present drug abuse? (Self / Sexual partner)
  If yes, what drugs _____ Intravenous? _____

Allergies

- Allergies (meds/food/Latex/anesthetics/seasonal)
  LIST: _____
  _____

Medication and Supplements (dose and regime)

_____

_____

_____

_____

_____

- Taken any steroids or other immunosuppressive drugs?
  Date: _____ Why? _____

_____ _____

Patient Signature Date