PLEASE COMPLETE PRIOR TO YOUR APPOINTMENT. Return Via:
Email:crosspatientcoordinator@verizon.net
Fax: 301-662-4945
OR Bring to your appointment

Patient Information

Patient Name: ______________________________ Date: ______________
Last First MI Preferred Name

Gender: Male OR Female Social Security #: ______________ Birth Date: ____________

Phone: Home____________ Work____________ Ext: ______ Mobile: ______________

Email Address: ______________________________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Health Information

1 – Has your Physician ever instructed you to take antibiotics prior to a dental appointment? (If No advance to question #4) YES OR NO

2 – If #1 Answer is YES please state reason for premed: ______________________________

3 – Did you premed today? YES OR NO

4 – Physician Information: Name and phone number:

____

5 - Have you ever had any of the following? Please check those that apply:

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ AIDS
- ☐ HIV positive
- ☐ Blood Diseases
- ☐ Anemia
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Drug Allergies
- ☐ Latex Allergies
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Angina
- ☐ Artificial Heart Valves
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Psychiatric Care
- ☐ Nervous Disorders
- ☐ Pregnancy Due date:_____
- ☐ PCOS(Polycystic Ovarian Syndrome)
- ☐ Respiratory Problems
- ☐ Asthma
- ☐ Cough, persistant
- ☐ Shortness of breath
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Gerd
- ☐ Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Cough up blood
- ☐ Tumors
- ☐ Tobacco Habit
- ☐ Thyroid Problems
- ☐ Veneral Disease
- ☐ Frequent Headaches
- ☐ Sleep Problems
- ☐ CPAP
- ☐ Other: ______________ ______________ ______________

6 - Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ______________________________

7 - Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ______________________________

8 - Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ______________________________

9 - Do you have any health conditions that need further clarification? ☐ Yes ☐ No
If yes, please explain: ______________________________

Please List Medications You Are Currently Taking **(If you have a preprinted list, attach here)**			
Medication Name	Dosage	Times per Day	Reason for Taking

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ **Date:** __________

Signature of patient, parent or guardian

DENTAL Insurance Information

Primary:

Name of Insured Employee: ____

Date of Birth: _______________________ Insurance Member ID #: ___________________

Insurance Company: ____
Insurance Company Address and Phone: ____
____

Insured Employer: ____

Group #:____

Secondary:

Name of Insured Employee: ____

Date of Birth: _______________________ Insurance Member ID #: ___________________

Insurance Company: ____
Insurance Company Address and Phone: ____
____

Insured Employer: ____

Group #:____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: ____________________
Signature of guarantor of payment/responsible party