Bethesda
SEDATION DENTISTRY

Date: _____

D.O.B: _____

New Patient [ ] Existing Patient [ ]

SS #: _____

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ (E-mail) _____

Occupation: _____ _____Company: _____

Sex: F ___ M ___ Marital Status: _____ Spouse Name: _____

HOW DID YOU HEAR ABOUT US?

Has any member of your immediate family been in this office before: _____

Name of that person: _____

Referred by another doctor or patient: _____

Did you hear our radio ad? _____ If so, which station? _____

Have you visited our website: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN ABOVE)

Name: _____ Relationship: _____ SS# : _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (H): _____ (W): _____

EMERGENCY NOTIFICATION

Name: _____ Phone: _____

Address: _____ Relationship to you _____

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and doctor and that I am responsible for all dental fees. Please let the office know if you will need an insurance form.

Signature Date

Bethesda Sedation Dentistry

Medical / Dental History

PATIENT NAME _____DATE_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain _____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No _____
Are you on a special diet? O Yes O No _____
Do you use **or** have you used tobacco products? O Yes O No What type _____ How long? _____
Have you stopped the use of tobacco products? O Yes O No If yes, when did you stop? _____
Does your family have a history of oral cancer? O Yes O No
Do you use controlled substances? O Yes O No

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O NSAIDs
O Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS?HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Recent Weight Loss	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Renal Dialysis	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Respiratory Problems	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	HPV	O Yes O No	Seizures	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Shingles	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sickle Cell Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Jaundice	O Yes O No	Sinus Trouble	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsilitis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Lesions (Congenital)	O Yes O No	Nervousness/Depression	O Yes O No	Tuberculosis	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Convulsions	O Yes O No	Heart Pace Maker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
		Heart Surgery	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
		Heart Trouble/Disease	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: _____
_____

Are you under a physician's care now? O Yes O No If yes please list Dr's name and # _____
Are you taking any prescription medications, herbal supplements, or over the counter drugs? O Yes O No If yes, please list all prescription, herbal, and over the counter medications taken:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is there any additional information that we should be aware of regarding your medical history? _____
_____
_____

Medical / Dental History

Do you have any of the following problems:

♦Sensitivity (hot, cold, sweet)	○ Yes ○ No
♦Tooth pain or discomfort when chewing	○ Yes ○ No
♦Headaches, earaches, neck pain	○ Yes ○ No
♦Jaw joint pain	○ Yes ○ No
♦Teeth or fillings breaking	○ Yes ○ No
♦Grinding or clenching teeth	○ Yes ○ No
♦Bleeding, swollen or irritated gums	○ Yes ○ No
♦Loose, tipped or shifting teeth	○ Yes ○ No
♦Bad breath or bad taste in your mouth	○ Yes ○ No

Do you have or have you had any of the following?

♦Dentures	○ Yes ○ No
♦Partial dentures	○ Yes ○ No
♦Braces	○ Yes ○ No
♦Periodontal (gum) treatments	○ Yes ○ No

Please share the following dates:

♦Your last cleaning	__ / __
♦Your last oral cancer screening	__ / __
♦Your last complete X-Rays	__ / __

What is the most important thing that you would like us to address, at today's dental visit?

_____

If I could change my smile, I would:

♦Make my teeth brighter	○
♦Make my teeth straighter	○
♦Close spaces	○
♦Replace black metal fillings with natural, tooth- colored fillings	○
♦Repair chipped teeth	○
♦Replace missing teeth	○
♦Replace old crowns that don't match	○
♦ Show less gum tissue when smiling	○
♦Have a smile makeover	○

On a scale of 1 – 10, with 10 being the highest rating:

♦How important is your dental health to you?	1 2 3 4 5 6 7 8 9 10
♦Where would you rate your current dental health?	1 2 3 4 5 6 7 8 9 10

What are your most important future goals for your smile and dental health?

_____

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

BETHESDA SEDATION DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ , have received a copy of this office's Notice of Privacy Practices (HIPAA)

Printed Name of Patient:_____

Signature: _____

Date: _____

If other than patient, specify relationship to patient_____

I hereby authorize the doctors and team to communicate information regarding my care, treatment or billing information to the following:

Name_____

Relationship_____

Phone number_____

_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials	Reason:

FINANCIAL AGREEMENT

Thank you for choosing Bethesda Sedation Dentistry to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving you is to be informative, honest and forthright.
Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have questions or concerns about our Financial Agreement please do not hesitate to ask a member of our team.

DENTAL INSURANCE

- To provide you with what we consider the very *best clinical care*, we are not network providers with any insurance company. This means that we can *recommend the procedures we deem best for your case*, regardless of what your insurance will pay for. Insurance companies place limits on coverage and will reimburse for set fees. An insurance company will only pay for "reasonable and customary fees." These fees are based on an average price charged by a range of dental clinics and practices. They don't factor in the *personalized care, excellent service, high quality materials, and amenities you enjoy at our office*. We would be happy to provide you with a universal insurance form for your care. You can submit the form to your insurance company for reimbursement.

PAYMENT PROTOCOL

- We will provide you with a written estimate of fees. When scheduling a visit for extensive care, we will request a deposit for fifty percent of the expected fees to be accrued during this upcoming visit. The remaining balance will be requested at the time the care is provided.
- We accept cash, personal checks, Visa, MasterCard, American Express and Carecredit.

FINANCE CHARGES AND COLLECTION FEES:

Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.75% on the balance then unpaid and owed will be assessed each month until paid. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any account balances 90 days overdue. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

CONSENT & AUTHORIZATION

I authorize dental treatment and agree to pay all related professional fees.

I have read and understood this document in its entirety, outlining office policies and financial policies of Bethesda Sedation Dentistry. Without any reservations, I agree to abide by the policies outlined herein.

Name_____Signature_____

Date_____