Welcome to Beltsville Dental Care

Patient Information

Name _____ **Today's Date** _____
First **Middle** **Last**

Address _____ **City, State, & Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Date of Birth _____ **Marital Status** _____ **Gender** _____ **E- mail** _____

Referred By: _____ **(Please ask about our Care Enough to Share Program)**

Responsible Party Information

Name of Responsible Party _____ **Social Security #** _____

Address (if different that above) _____

Occupation _____ **Employer** _____ **Work Phone** _____

How would you like to pay for your portion of the provided services? Cash [ ] Check [ ] Credit Card [ ]

Dental Insurance

Insurance Company _____ **Insured Name** _____

Insured Date of Birth _____ **Subscriber ID #** _____ **Group #** _____

Employer _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Secondary Dental Insurance

Insurance Company _____ **Insured Name** _____
Insured DOB _____ **Subscriber ID #** _____ **Group #** _____
Employer _____
Insurance Co. Address _____
Insurance Co. Phone # _____

Patient Dental History

Date of last dental visit _____ **Last dental cleaning** _____ **Last full mouth x-rays** _____
Do you require medication prior to Dental Treatment? □ Yes □ No
Which of these dental-aids do you use? Sonicare □ Braun □ Toothpicks □ Bleach Kits □ Floss □
Do you clench or grind your teeth? Yes □ No □ Do you wear a Night Guard? Yes □ No □
Do you have active dental problems now? Gum Disease □ Bleeding Gums □ Broken Teeth □ Decay □
Have you ever had gum surgery? Yes □ No □

Patient Medical History

Please check the conditions listed below that apply to you.

- ☐ AIDS
- ☐ Allergies _____ (Hayfever) _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ HIV
- ☐ Head Injuries
- ☐ Heart Disease, Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ STDS
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other: _____
- ☐ Stomach Problems
- ☐ Epilepsy

Have you ever taken any Medication for Osteoporosis? (Fosamax, Zometa, Aredia,or Actonel) ☐ Yes ☐ No

Have you had any complications due to Dental Treatment? ☐ Yes ☐ No
If yes please explain _____

Have you been admitted to a Hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes please explain _____

Are you under a physicians care now? ☐ Yes ☐ No Name of family Physician _____

Do you have any health problems that need further clarification? _____

Please list all medications that you are currently taking _____

Financial Agreement

This office participates with CareFirst, Delta Dental, and Denta Quest Choice. Patients who carry dental insurance understand that all services furnished are charged directly to the patient and that he or she is personally responsible for payment for all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance. We offer a 5% discount to our patients who pay their treatment plans up front in full.

A service charge of 1 ½ % 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. If the account is not cleared, the account will be turned over to collections and a 30% collection fee will be added.

Any checks returned to the office are subject to an additional fee of $25.00.
If for any reason you are unable to keep your appointment, 48 hours notice must be given to avoid the 60.00 broken appointment fee.

I have read the above conditions of treatment and payment and agree to their content. All the above answers and information provided are true and correct. If I have any change in my health I will notify the doctors on my next appointment.

_____ Date _____ Relationship to patient _____
Signature of patient, parent, or guardian

_____ Date _____ Relationship to patient _____
Signature of guarantor of payment