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	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies ____________ (Hayfever) ____________	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
☐ Anemia	☐ Glaucoma	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ HIV	☐ Pregnancy	☐ STDS
☐ Artificial Joints	☐ Head Injuries	☐ Radiation Treatment	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease, Heart Attack	☐ Respiratory Problems	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatic Fever	☐ Other: ____________
☐ Cancer	☐ Hepatitis	☐ Rheumatism	
☐ Diabetes	☐ High Blood Pressure	☐ Sinus Problems	☐ Stomach Problems
☐ Dizziness	☐ Jaundice	☐ Kidney Disease	☐ 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, 24 hours notice must be given to avoid the 51.00 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