Perio & Implant at Washington Metro

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PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient Name: _____ **Date Of Birth:** _____
First, Last, Middle (Preferred)

If minor, parent's/guardian name: _____

Social Security #: _____ **Gender:** ☐Male ☐ Female **Family Status:** ☐Married ☐Single

Home#:_____ **Work#** _____ **Ext:** _____**Cell#:**_____

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address: _____

Who we should thanks for your referral? _____

General dentist practice name: _____ **Phone#:** _____

Address: _____

Spouse or Responsible Party Information

The following is for: ☐The patient's spouse ☐ The person responsible for payment ☐Guarantor of insurance

Name: _____ **Date of Birth:** _____

Social Security #:_____ **Gender:** ☐Male ☐Female **Family Status:** ☐Married ☐Single

Home Phone: _____ **Work:** _____ **Ext:** _____ **Best time to call:** _____

Address: _____
Street City State Zip code

Employment Information

The following is for ☐The patient ☐The person responsible for payment

Employer name: _____ **Occupation:** _____

Address: _____
Street City State Zip code

Insurance Information

Name of insured: _____ **Is insured a patient?** ☐Yes ☐No
First, Last, Middle

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other **Insurance Name:** _____

Insurance ID #:_____ **Group #:**_____ **Insurance Phone #:** _____

Insurance Address: _____
Street City State Zip code

Patient Health History

Date of last dental visit: _____ **Reason for visit today: _____**

Have you ever had, or now have any of the following? Please check all that apply:

- ☐ **AIDS**
- ☐ **Allergies**
- ☐ **Allergy – Aspirin**
- ☐ **Allergy- Latex**
- ☐ **Allergy – Codeine**
- ☐ **Allergy – Erythro**
- ☐ **Allergy – Penicillin**
- ☐ **Allergy – Hay Fever**
- ☐ **Allergy – Sulfa**
- ☐ **Allergy – Other _____**
- ☐ **Anemia**
- ☐ **Arthritis, Rheumatism**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Back Problems**
- ☐ **Bleeding abnormally, with extractions or surgery**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Chemical Dependency**
- ☐
- ☐ **Chemotherapy**
- ☐ **Congenital Heart Lesions**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Epilepsy**
- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Head Injuries**
- ☐ **Headaches or Migraines**
- ☐ **Heart Problems**
- ☐ **Hepatitis : Type _____**
- ☐ **Herpes**
- ☐ **High Blood Pressure**
- ☐ **HIV**
- ☐ **Jaundice**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Mitral Valve Prolapse**
- ☐ **Mental / Nervous Disorders**
- ☐ **Pacemaker**
- ☐ **Women: Are you pregnant? Due Date : _____**
- ☐ **Psychiatric Care**
- ☐ **Radiation Treatment**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Swollen Neck Glands**
- ☐ **Thyroid Problems**
- ☐ **Tuberculosis**
- ☐ **Tonsillitis**
- ☐ **Tumor or growth on head or neck**
- ☐ **Ulcer**
- ☐ **Venereal Disease**
- ☐ **Other: _____**

Are you currently taking any medications or substances? ☐Yes ☐No

If yes, please list:

_____

Have you ever had any complications following dental treatment? ☐Yes ☐No

If yes, please ist:_____

Have you been admitted to the hospital or needed emergency care during the past two years? ☐Yes ☐No

If yes, please list:

_____

Are you under the care of a physician? ☐Yes ☐No

If yes, please list:

_____

Name of physician:

_____**Phone:**_____

Do you have any health problems that need further clarification? ☐Yes ☐No

If yes, please explain:

_____

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.

Signature of patient/ Parent or guardian: _____ Date: _____

Consent for Services

Patients who carry dental insurance understand that all dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Perio and Implant at Washington Metro. Will assist in preparing insurance claims and follow up with any insurance requests. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any emergency dental services rendered are payable in full on the day of service, All personal checks returned will carry a "Returned Check Fee" of $35.00. Any outstanding account balances over 30days after services rendered, are deemed "*delinquent*" and are subject to *Collections,* which will incur collection fees not to exceed 40% of the account balance.

The Patient will agree to pay any and all legal costs incurred in any legal action brought by the Patient against Perio and Implant at Washington Metro, its employees, staff, directors, officers, shareholders or affiliates, in the event Perio and Implant at Washington Metro prevails in its defense. The Patient will pay costs incurred in the collection of any delinquent charges, including, but not limited to, collection fees, interest and reasonable attorney fees. The patient agrees to provide the Office with current, accurate and truthful information and agrees to abide by the medical advice including, but not limited to, making and keeping scheduled appointments as directed by her care provider. Patient agrees to furnish the office with a valid, working telephone number and a current address at all times.

Consent for Treatment

I hereby authorize my doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff to use and disclose any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.

I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time service unless other financial arrangements or agreements have been made. In the event that payments are not received by agreed upon dates, I understand that a 1 ½ late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.

I have read the above conditions for treatment and services, and agree to their consent.

_____ **Date:** _____ **Relationship:** _____

Signature of patient/ Parent or guardian

_____ **Date:** _____ **Relationship:** _____

Signature of patient/ Parent or guardian

Office Policies

Financial Arrangements

Our doctors and staff are proud to be a team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your dental care and want to ensure you that it is performed in the most responsible manner. In order to assist you with the investment in your dental health, we have outlined our payment policy.

Missed Appointments

Our office tries to accommodate each patient in working with their schedule, so it is important that you notify us in advance when changes occur .You must cancel your appointment at least and **48 hours in advance**, or it will be treated as a missed appointment. There will be a $100.00 charge for general missed appointments and a $150.00 charge for surgical missed appointments.

Emergency/Single-Visit

We realize dental emergencies happen and that it leaves little room for planning financially, however once treatment is accepted payment is due at time of services rendered.

Payment Options

For your convenience we accept cash, checks, money orders, and credit card payment (**MasterCard**, **Visa**, **Discover**, and **American Express**).

***All treatment prepaid in advance is eligible for a 5% discount off the total fee

Outside Financing – For those who would prefer an extended payment plan or interest free payment plan, we offer two outside financing sources; Care Credit and The Lending Club Finance Company. Applications are available in office for your convenience. (Please see the Receptionist for further information)

Insurance

Insurance claims will be filed on your behalf; however payment is due in full at time services are rendered unless other financial arrangements have been made in advance. Any information given regarding insurance coverage or reimbursement is an "*estimate*" only and not a guarantee of payment. This information is made available per your insurance carrier. We file your insurance claim as a courtesy and duty as a contracted provider; however it is your responsibility to know the details of your coverage and its limitations. For those insurance carriers that we don't participate with, we will happily file a claim on the patient's behalf.

*****Any emergency dental services rendered are payable in full on the day of service, All personal checks returned will carry a "Returned Check Fee" of $35.00. Any outstanding account balances over 30days after services rendered, are deemed "*delinquent*" and are subject to *Collections,* which will incur collection fees not to exceed 40% of the account balance. Any patient with unpaid balances that have been forwarded to a collection agency will NOT receive services unless the balance has been **paid in full** to include all collection fees or unless emergency care is needed.

*****All financial arrangements must be in writing and scheduled before treatment is started***

I consent to receive communication via cell phone; to include messages left regarding accounts, appointments and other dental related information.

_____ ***Date:*** _____

Signature of patient/ parent or responsible party

I have read and consented to the financial policies as stated by Perio and Implant at Washington Metro, and agree to its terms and conditions.

_____ ***Date:*** _____

Signature of patient/ parent or responsible party

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy Notice of Privacy Practices.

{Please Print Names}_____

{Signature}_____

{Date}_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

☐ **Individual refused to sign**

☐ **Communications barriers prohibited obtaining the acknowledgement**

☐ **An emergency situation prevented us from obtaining acknowledgement**
☐ **Other (please Specify)**
