BETHESDA DENTAL GROUP

Patient Registration

Patient Information

Name: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Phone #: _____ Email: _____
Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Partnership ☐Widowed
Employer or School: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Parent Name (if applicable): _____
Emergency Contact: _____ Phone: _____
How did you learn about our practice or whom may we thank for referring you? _____
Who is responsible for your account and payment? _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____ Birthdate: _____
Who may we thank for reffering you to our office? ☐Yelp ☐Google ☐Yahoo ☐Family/friend who_____

Dental Insurance

Insurance Company: _____ Phone: _____
Subscriber's Social Security #: _____ Group #: _____ ID #: _____
Address: _____ City: _____ State: _____ Zip: _____
How much is your deductible? _____ How much have you used?_____
What is your annual maximum benefit? _____
Whose name is this insurance under? _____
Employer offering this insurance? _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Insurance Company: _____ Phone: _____
Subscriber's Social Security #: _____ Group #: _____ ID #: _____

Address: _____ City: _____ State: _____ Zip: _____
How much is your deductible? _____ How much have you used?_____
What is your annual maximum benefit? _____
Whose name is this insurance under? _____
Employer offering this insurance? _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit:_____
Date of last dental care visit: _____ Date of last dental x-rays: _____
Check if you have any problems with the following:

☐ Bad breath or unpleasant taste
☐ Bleeding/sore gums
☐ Clicking or popping jaw
☐ Food collection between certain teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to any of the following: cold, hot, sweets
☐ Sensitivity when biting
☐ Sores or growth in your mouth

Any other dental problems or concerns:_____
_____
_____

Medical History

Primary physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates: _____

Women: are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control? ☐ Yes ☐ No

Check if you have or have had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artifical Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst Fainting
- ☐ Spells/Dizziness Frequent
- ☐ Cough Fredquent
- ☐ Diarrhea Fredquent
- ☐ Headaches Genital
- ☐ Herpes Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker Health
- ☐ Trouble/Disease
- ☐
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregulat Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease Mitral
- ☐ Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weightloss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyoid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Any other serious illness not listed above:_____

_____

List medications you are currently using and the correlating diagnosis:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any allergies that you may have:

_____ _____

_____ _____

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature Date

BETHESDA DENTAL GROUP

PATIENT AUTHORIZATION & FINANCIAL POLICY

OUR FEES:

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist in this effort when you pay for our services at each visit. New patients and those requiring emergency care (without insurance) are expected to make full payment at the time of their appointments. Our staff can tell you the approximate fees for treatment before your appointment. Please understand that the amount stated is only an estimate and does not reflect any additional work that may be needed and/or is performed and it does not take into account what your insurance ultimately decides is and isn't covered. To make payments convenient for you we accept cash, cashier's checks, money order, all major credit cards, and Care Credit.

INSURANCE PLANS:

We are proudly a dental office that participates with several insurance carriers. Please check with our Staff before treatment to determine if we are in network with your insurance. We expect covered patients to read their policy carefully, to become familiar with its benefits and limitations, and to bring a copy of their insurance card with them to each and every appointment. Please understand that your insurance policy is a contract between **you and your insurance company.** It is important that you understand in most cases your insurance is designed to reduce your cost, NOT to eliminate it completely. **You are ultimately responsible for the full unpaid balance of your bill, including any unpaid portion that your insurance does not cover.** Patients are expected to pay their deductible and co-payment percentages at the time of service. Any difference will be billed after your insurance is processed. Any insurance payment not received after thirty (30) days of filing becomes the responsibility of the patient. Patient's payment is expected within ten (10) days of notification.

FINANCIAL OBLIGIATIONS:

- **If your account is outstanding for more than sixty (60) days, it will be referred to an outside collection agency or attorney. A monthly interest charge of 1.5% (18% annually) will be added to the balance. Patients will be responsible for any and all costs of collections including attorney's fees of 15% and court costs.**
- Any checks returned to our office are subject to an additional fee of $25.00. Immediate remittance in the form of cash, money order, and/or certified funds is expected.
- If a patient does not cancel an appointment within 48 hours of said appointment there will be a no show fee applied to their account. The no show fee for appointments during our normal hours of operation (Monday through Friday from 8 AM to 5 PM) will be $75.00 per half hour of missed appointment ($150.00 maximum) and for emergency appointments, meaning outside of our normal hours of operations, will be $150.00.

HIPPA NOTICE: All patients will have an opportunity to review the HIPPA notice and may have a copy of said notice upon request. They will also received a copy of this office's notice of privacy practices.

If you have any questions about our policies or your account at any time, please do not hesitate to contact a member of our Staff for assistance.

I have read the above policy and agree to accept all financial responsibilities. I understand that I am personally responsible for any unpaid bills. I authorize the release of any information necessary to process my dental claim. I acknowledge review of the HIPPA notice and have received a copy of this office's notice of privacy practices.

_____ _____

(Patients Name) (Date)

_____**(Seal)** _____

(Signature) (Relationship to Patient)