Thurmont
FAMILY DENTISTRY

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information

Address: _____

City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Preferred Method of Notification: text ☐ email ☐ phone ☐

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Preferred Pharmacy: _____

Section 3

Marital Status:

☐ Married ☐ Single ☐ Divorced

☐ Separated ☐ Widowed

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: or ID # _____ Insured Birth Date: _____

Group #: _____

Ins. Company: _____

Employer: _____

Secondary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: or ID # _____ Insured Birth Date: _____

Group #: _____

Ins. Company:

Employer: _____

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Your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dental care you receive. Thank you for answering all of the following:

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form 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:

X _____ **Date:** _____

Thurmont
FAMILY DENTISTRY

105 E. Main Street
Thurmont, MD

301.271.2346
office@thurmontfamilydentistry.com
thurmontfamilydentistry.com

Dental History

- ☐ Are your teeth sensitive to:
  Heat? ❑ Yes ❑ No Cold? ❑ Yes ❑ No Sweets? ❑ Yes ❑ No Biting Pressure? ❑ Yes ❑ No
- ☐ Does food constantly get stuck between certain teeth in your mouth? ❑ Yes ❑ No
- ☐ Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ❑ Yes ❑ No
- ☐ Are you dissatisfied with your teeth in any way? ❑ Yes ❑ No
- ☐ Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ❑ Yes ❑ No
- ☐ Do you have any fillings that show in your front teeth? ❑ Yes ❑ No
- ☐ Do any of your fillings show when you smile? ❑ Yes ❑ No
- ☐ If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? ❑ Yes ❑ No
- ☐ Have you ever had any teeth removed? ❑ Yes ❑ No
  How long have these teeth been missing? _____
- ☐ Do your gums bleed when brushing? ❑ Yes ❑ No
- ☐ Do you ever avoid any part of the mouth while brushing? ❑ Yes ❑ No
- ☐ Have you been instructed regarding proper home care? ❑ Yes ❑ No
- ☐ Do you have an unpleasant taste or odor in your mouth? ❑ Yes ❑ No
- ☐ Do you smoke? ❑ Yes ❑ No
- ☐ Do you frequently snack between meals on sweets or chew gum? ❑ Yes ❑ No
- ☐ How often do you brush your teeth? _____
- ☐ Do you use dental floss? ❑ Yes ❑ No
  How often? _____
- ☐ Do you want to learn to control dental disease and retain your teeth? ❑ Yes ❑ No
- ☐ Has the fear of discomfort kept you from regular dental visits? ❑ Yes ❑ No
- ☐ Are you deeply concerned about the finances required to return your mouth to excellent dental health? ❑ Yes ❑ No
- ☐ When was your last dental appointment? _____
- ☐ What did you have done? _____
- ☐ How long since your last thorough examination with full mouth x-rays? _____
- ☐ What prompted you to seek dental care at this time? _____
- ☐ Why did you leave your last dentist? _____

Remarks

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HIPAA & NOTICE OF PRIVACY PRACTICE

OPTIONAL: Name of Personal Representative, Family Member, or anyone else whom you want to grant authorized access to your protected health information regarding treatment, appointments, billing and other inquiries.

- ☐ I authorize release of all information to: _____
- ☐ CHECK HERE IF YOU REQUEST A COMPLETE COPY OF THE NOTICE OF PRIVACY PRACTICE DATED 04/04/2003.

SIGN BELOW AGREEING TO HIPPA & NOTICE OF PRIVACY PRACTICE.

Signature: _____ **Date** _____

FINANCIAL POLICY

For your convenience we offer several options of payment: Cash, Check, Debit or Credit Card. We also have companies willing to finance dental treatment with no money down. Payment arrangements must be agreed upon before procedure is initiated. If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. ***Each patient will receive an estimate for treatment needed, which will include their co-pays and deductibles. This is only an estimate and you are responsible for amounts not paid by the insurance. We cannot guarantee what insurance will or will not pay***. **All estimated payments are due at time of service.** If your insurance neglects to pay within 60 days, the balance on the account becomes your responsibility. If your account becomes delinquent, it will be turned over to a local collection agency.

Patient Initial: _____

If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 18%, court costs, and attorney fees as allowed by law.

Patient Signature / Guardian SEAL _____ **Date:** _____

We reserve the right to charge $50.00 per hour for all broken/cancelled appointments that do not allow 48-hour notice. For any major treatment, you may be expected to apply a reservation fee payment at the time of scheduling. As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care for you, your family and friends. Your account will be charged a return check fee in the amount of $35 for any check returned unpaid.

Patient Initial: _____

By signing below, I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to **Thurmont Family Dentistry**.

Please read carefully before signing this agreement.

Signature:_____ **Date:** _____/_____/_____

Print Name: _____

Record Release Form

Thurmont
FAMILY DENTISTRY
Dr. Sarah Raymond DDS • 105 E. Main St. Thurmont, MD

Phone: 301-271-2346 Fax: 301-271-4412
office@thurmontfamilydentistry.com

I, _____ *hereby authorize*
(Patient's Name)

_____
(Former Dentist's Name)

to provide _____.

with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian, or POA of the patient, if patient is unable to sign for themselves)

Address to where records should be sent: _____

_____

_____

Email: _____

Date: _____