

Welcome!

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

Patient Information

Name _____
Last First MI

Preferred Name _____ Title _____

Male Female Single Married Other

Birthdate _____ SSN _____

Driver's Lic. _____ State _____

Address _____

City _____ State _____ ZIP _____

Email _____ Employer _____

Home Phone _____ Work _____

Emergency Contact _____

Emergency Phone _____

How did you hear about us? _____

Responsible Party:

Insured/Gaurdian _____

Insured's SSN _____ Insured's DOB _____

Insurance Company _____

Employer _____ Group _____

Insured's Relationship to Patient _____

Insurance Phone _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Patient Date

Office Policies

We have established the following office policies. Please place your initials by each to indicate that you have read them.

- _____ Payment and/or co-payment is required in full at the time services are provided.
- _____ A **\$10** infection control fee is charged for each visit. This fee covers the disposable items and the sterilization and disinfectant technology involved in your visits as required by law (OSHA). More information about this is available at the front desk.
- _____ At least 48 hours advance notice is required for all appointment changes or cancellations. Otherwise, a \$25 fee is charged for each appointment so affected; an additional \$25 cancellation fee is charged for appointments with specialists.
- _____ If you have any questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations. **Please note that dental insurance is very different than medical insurance and that in most cases a co-payment is required.**
- _____ Please be advised that the co-payment requested for services rendered is only an estimate of what the insurance will not cover, as determined from the information provided by the insurance company. The information given to our office is not a guarantee of payment, and the actual insurance benefit may differ from our estimates. **The account holder is responsible for whatever the insurance company does not pay within 45 days.**
- _____ Valid identification is required for all personal checks. A \$35 fee is charged for each returned check. Accounts not reconciled within 10 days of a check return will be charged an additional \$50 fee for legal pursuit of the issue.
- _____ Past due accounts (having a balance due for more than 60 days) will be charged 1.5% interest per month until account is reconciled. Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency. Any and all charges incurred in the pursuit of the debt by that agency or any other third party will be the full responsibility of the account holder.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

Responsible Party Signature Date

Over Please...

Dental Health History

Name: _____

Reason for today's visit _____

Former Dentist _____

Phone _____

Date of last dental exam _____

Date of last dental x-rays _____

Date of last cleaning _____

How often do you brush? _____

How often do you floss? _____

Do you feel pain anywhere? _____

Describe _____

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Sensitivity to hot or cold	Yes	No
Sensitivity to sweet	Yes	No
Avoid one side of the mouth when chewing	Yes	No
Sensitivity when biting	Yes	No
Broken / cracked fillings	Yes	No
Food collection between teeth	Yes	No
Tobacco use	Yes	No
Gums swollen or tender	Yes	No
Gums bleed frequently	Yes	No

Blisters on lips or mouth	Yes	No
Sores or growths inside cheek / in the mouth	Yes	No
Bad breath	Yes	No
Burning sensation on tongue	Yes	No
Dry mouth	Yes	No
Accident involving jaw	Yes	No
Clicking or popping jaw	Yes	No
Frequent headaches	Yes	No
Grinding teeth	Yes	No
Jaw pain or tiredness	Yes	No
Pain around ear	Yes	No
Orthodontic treatment	Yes	No
Periodontal treatment	Yes	No

Medical Health History

Physician _____ Phone _____

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

Are you allergic to any of the following?

Aspirin Codeine Latex Penicillin Valium

Other: _____

Have you ever had any of the following conditions?

Artificial joint/valve Heart murmur Mitral valve prolapse Rheumatic fever

Women Only:

Do you use birth control medication?	Yes	No
Are you nursing?	Yes	No
Are you pregnant? (Due date: _____)	Yes	No

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

AIDS / HIV	Yes	No
Anemia	Yes	No
Arthritis or Back problems	Yes	No
Asthma or Respiratory problems	Yes	No
Blood transfusion (Date: _____)	Yes	No
Cancer	Yes	No
Cardiac pacemaker	Yes	No
Convulsions / Epilepsy / Seizures	Yes	No
Diabetes	Yes	No
Excessive bleeding with extractions / surgery	Yes	No
Heart problems	Yes	No
Hepatitis or Liver problems	Yes	No
High / Low blood pressure	Yes	No
Kidney problems	Yes	No
Phen-Phen treatment	Yes	No
Radiation or Chemotherapy treatment	Yes	No
Sexually transmitted disease	Yes	No
Stroke	Yes	No
Thyroid disorder	Yes	No
Tuberculosis	Yes	No

Other: _____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

X

Responsible Party Signature

Date

X

Attending Dentist Signature

Date

Congressional Dental Care
1750 Rockville Pike
Suite 10
Rockville, MD 20852
301.770.5400
301.770.6642 fax



FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy so that we minimize our billing cost. **ALL PATIENTS MUST COMPLETE OUR OFFICE HEALTH HISTORY AND FINANCIAL POLICY IN ITS ENTIRETY PRIOR TO BEING SEEN BY THE DOCTOR.** Payment is expected at time of service, unless other arrangements have been made, prior to the treatment.

INSURANCE:

The patient (or responsible party) is responsible to pay any deductible and percentage **AT THE TIME OF SERVICE**. If payment is not made on the treatment date, the office will not honor the insurance benefit, and the patient will be responsible to pay usual and customary fees. The percentage quoted to you is **an estimate** and not a guarantee of payment from your insurance company. In order for us to file claims on your behalf, you must supply us with all the necessary insurance information. Please refer to your insurance manual for specific coverage. Your insurance policy is a contract between you and your insurance company and we file your claim as a courtesy. If your account has not been paid within 45 days, **the balance will be due in full by you, regardless of insurance status.**

For the plans which we are a participating provider, we will submit the claim for you. The plans which we are not a participating provider, we will submit the claim to your insurance carrier. If an overpayment occurs, we will refund the payment to you at our earliest convenience.

MINOR PATIENTS:

Unaccompanied minors will not be seen without written permission from a parent or guardian. The parent, guardian or adult accompanying a minor is responsible for full payment, their deductible or percentage, **AT THE TIME OF SERVICE**. For unaccompanied minors, non-emergency treatment will be denied unless charges have been prepaid or the minor comes prepared **AT THE TIME OF SERVICE**.

FINANCE CHARGES

Any account balance carried over 45 days will be subject to 1.5% interest fee per month. In the event the account is turned over to a collection agency, the patient or responsible party shall be liable for any clerical, legal and collection fees incurred, up to 30% of the outstanding balance. Also, please note, balances sent to our collection agency will be billed to our usual customary fees, which will forfeit your insurance benefits.

I UNDERSTAND AND AGREE TO THIS POLICY

SIGNATURE OF PATIENT/GUARDIAN

DATE