PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID: 1297601

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: Hampstead, MD 21074 | **Email:**

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:
	(410) - x				Unknown

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex: Male

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height:

For Office Use Only
BP / Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Acid Reflux Or Gerd
☐	☐	Alcohol Or Drug Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Bacterial Endocarditis
☐	☐	Bleeding Disorders
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Defibrillator
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Do You Require Pre-Medication For
☐	☐	Eating Disorder
☐	☐	Emphysema
☐	☐	Epilepsy

Y	N	Conditions
☐	☐	Fainting Spells
☐	☐	Flu-Like Symptoms (Vomiting, Feve
☐	☐	Frequent Headaches
☐	☐	HIV+ Or AIDS
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Heart Valve Replacement/Stents
☐	☐	Hemophilia
☐	☐	Hepatitis (List Type)
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Osteoporosis/Osteopenia
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Surgery Involving Plates, Rods
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SS# _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# Cell : E-MAIL#

PLACE OF EMPLOYMENT _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME # WORK# FAX# E-MAIL#

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME # WORK# FAX# E-MAIL#

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

DENTAL HISTORY

NAME _____ **DATE** _____

Approximately, how long has it been since your last dental exam? _____

Please Circle

Do you have a specific dental problem? Describe _____ Y N

Do you think you have active decay or gum disease? _____ Y N

Do you brush and floss on a routine basis? Discuss _____ Y N

Do your gums ever bleed? Discuss _____ Y N

Do you like your smile? Why? _____ Y N

Does food catch between your teeth? Any loose teeth? _____ Y N

Do you want to keep your remaining teeth? _____ Y N

Do you ever have clicking, popping or discomfort in the jaw joint? _____ Y N

Have your past experiences in a dental office always been positive _____ Y N

Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Y N

Have you ever been diagnosed with sleep apnea/snoring? _____ Y N

Name of previous dentist (optional): _____ Y N

Date of last full mouth x-rays (16 small films or panoramic): _____ Y N

FINANCIAL OPTIONS

Date _____ Amount of treatment _____

I, _____ choose the following method of payment for my dental care and the care of my dependents.

Please initial your preferences.

1. I have no dental insurance.

____ A. I elect to pay cash ____, check ____ and receive a 5% professional courtesy.

____ B. MasterCard ____, VISA ____, Discover ____, on all visits as treatment progresses.

____ C. I wish to apply for your no interest in-office finance plan (Care Credit). *

____ D. I elect to pay 50% on the preparation date and the balance on completion or delivery date.

____ E. Pay at each visit and receive a 15% discount by participating in our Loyalty Program. **

2. I have dental insurance through _____.

____ A. I elect to pay my deductible of $ _____ and the estimated uninsured portion at each visit.

____ B. I elect to pay 50% of my estimated uninsured portion on the preparation date and the balance on completion or delivery date.

____ C. With credit approval, I elect to pay my entire estimated uninsured balance using CareCredit no interest financing (or other financing institution).

Patient _____ Date _____

Responsible party (if minor) _____ Date _____

* **Speak with any of our front desk staff regarding CareCredit financing**

** **Loyalty Program discounts cannot be combined with any other offers or discounts, including CareCredit.**

Resh family dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices ("Notice") before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Our office administrative team

Telephone: 410-374-5900

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the practice. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I certify that I have read the Notice of Privacy Practices ("Notice"), which contains a more detailed description of the uses and disclosures of my health information and is available on the website located at https://www.reshdentisty.com and at the practice office. I understand that in accordance with the Health Insurance Portability and Accountability Act of 1996 (also known by its acronym, "HIPAA"), I have certain rights to privacy regarding my protected health information I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____