ELLICOTT MILLS DENTAL

PATIENT INFORMATION

DATE _____

PATIENT'S NAME _____
LAST FIRST MIDDLE

BIRTHDATE _____ SOCIAL SECURITY # _____

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

If patient is a minor, parent's or guardian's name _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

EMERGENCY CONTACT _____
NAME PHONE NUMBER

RESPONSIBLE PARTY/INSURANCE INFORMATION

☐ SAME AS ABOVE (SKIP TO INSURANCE INFORMATION REQUEST)

SUBSCRIBER'S NAME _____
LAST FIRST MIDDLE

MAILING ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S SOCIAL SECURITY/MEMBER # _____ GROUP # _____

INSURANCE COMPANY _____ PHONE # _____

Do you have dual coverage? YES ___ No ___ If yes: Please complete the following secondary insurance information:

SUBSCRIBER'S NAME _____
LAST FIRST MIDDLE

SUBSCRIBER'S SOCIAL SECURITY/MEMBER # _____ GROUP # _____

INSURANCE COMPANY _____ PHONE # _____

_____
PATIENT'S SIGNATURE (OR PARENT/RESPONSIBLE PARTY) DATE

_____
PRINTED NAME

DENTAL HISTORY

Prior to visiting our office, had you been seeing your dentist and hygienist regularly? _____

Approximate date of your last dental exam and cleaning: _____

Was any treatment recommended that has not been completed? _____

Are you currently experiencing any pain or discomfort with your teeth? _____

-If yes, please describe: _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you use a manual (hand held) or electric toothbrush? _____

Have you ever been treated for periodontal disease? (gum disease) _____

Do you gums bleed when you brush? _____

Are you teeth sensitive to: (indicate area of mouth and severity: mild, moderate, or severe)

Hot? _____ Cold? _____

Chewing? _____ Brushing? _____

Do you clench or grind your teeth? Do you have any pain or popping/clicking in your jaw? ____

Do you wear a nightguard? ____ Do you experience frequent headaches? ____

Is there anything you would like to change about the appearance of your teeth? _____

_____

Do you have any specific concerns you would like to discuss? _____

_____

Do you have fear or anxiety about receiving dental treatment? _____

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MEDICAL HISTORY

PLEASE FILL OUT BOTH SIDES, SIGN, AND DATE

Name: _____ Date of birth: _____

Physician's name and phone number: _____

Have there been any changes in your health in the past year? ____ If so, please explain: _____

_____ Date of last physical: _____

Current medications (including herbal and over the counter medications):

_____

_____

Drug allergies:

_____

Food allergies:

_____

Are you allergic to or sensitive to latex? _____ Are you able to climb stairs? _____

Are you sensitive to any dental anesthetics or epinephrine? _____

Do you have an artificial heart valve or a history of bacterial endocarditis? _____

Have you ever taken bisphosphonates? (bone density drugs, e.g. Boniva, Fosamax, Actonel or Reclast) _____

If yes, date of last dose: _____

Do you smoke? _____ If yes, how many cigarettes or cigars per day? _____

Do you vape? _____ If yes, how often? _____

Do you use cannabis? _____ If yes, in what form and how often? _____

Do you drink alcohol? _____ If yes, how many drinks per week? _____

Do you snore? _____ Do you have sleep apnea? _____ Do you wear a CPAP? _____

Women: Are you pregnant? _____ If so, what month? _____ Nursing? _____

Taking oral contraceptives? _____

PLEASE CHECK YES OR NO TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

YES NO CARDIOVASCULAR

- ☐ ☐ HIGH BLOOD PRESSURE
- ☐ ☐ ANGINA
- ☐ ☐ HEART ATTACK
- ☐ ☐ STROKE

YES NO ENDOCRINE

- ☐ ☐ DIABETES
- ☐ ☐ THYROID DISEASE

YES NO RESPIRATORY

- ☐ ☐ ASTHMA
- ☐ ☐ EMPHYSEMA
- ☐ ☐ TUBERCULOSIS
- ☐ ☐ COPD

YES NO IMMUNOLOGICAL

- ☐ ☐ AUTOIMMUNE DISEASE
- ☐ ☐ HIV/AIDS
- ☐ ☐ ARTHRITIS
- ☐ ☐ LUPUS
- ☐ ☐ MULTIPLE SCLEROSIS
- ☐ ☐ SJOGREN'S SYNDROME

YES NO MUSCULOSKELETAL

- ☐ ☐ FIBROMYALGIA
- ☐ ☐ OSTEOPOROSIS

YES NO HEMATOLOGIC

- ☐ ☐ ANEMIA
- ☐ ☐ SICKLE CELL DISEASE
- ☐ ☐ CLOTTING DISORDER

YES NO GASTROINTESTINAL

- ☐ ☐ ACID REFLUX/GERD
- ☐ ☐ IRRITABLE BOWEL DISEASE
- ☐ ☐ STOMACH ULCERS

YES NO HEPATIC (LIVER)

- ☐ ☐ CIRRHOSIS
- ☐ ☐ HEPATITIS A, B OR C
- ☐ ☐ JAUNDICE

YES NO NEUROLOGICAL

- ☐ ☐ EPILEPSY/SEIZURES
- ☐ ☐ PARKINSON'S DISEASE
- ☐ ☐ MULTIPLE SCLEROSIS

YES NO MENTAL HEALTH

- ☐ ☐ BIPOLAR DISORDER
- ☐ ☐ DEPRESSION
- ☐ ☐ ANXIETY
- ☐ ☐ EATING DISORDER
- ☐ ☐ DEMENTIA
- ☐ ☐ SLEEP DISORDER

PLEASE LIST ANY CONDITIONS YOU HAVE WHICH ARE NOT LISTED ABOVE: _____

_____

Patient's or guardian's signature: _____ Date: _____

FINANCIAL POLICY

DR. KIMBERLY M. FORD & ASSOCIATES

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patient are expected to pay for our services prior to the start of service. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible prior to the start of service. Payments may be made using cash, check, Visa, MasterCard, Discover, and/or American Express. We also offer CARECREDIT which is a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 1.5% per month past 60 days.

Optional payment terms:

1. Full pay cash discount: We offer a 5% accounting courtesy for all services that are paid in full by either cash or check, prior to the commencement of services.

2. Financing: By arrangements with CARECREDIT we can offer patients upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee and no prepayment penalty. Longer term financing is also available up to 60 months, subject to interest, with no down payment, no annual fee, and no pre-payment penalty. Ask for an application.

There will be a fee for any additional procedures not included in the original treatment plan that become necessary during the course of treatment.

Appointments:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. **We require at least 48 business hours' notice for any cancellation or change of appointment. If 48 business hours is not given, there will be a $50 charge per standard appointment time with an extra $25 per additional half hour scheduled thereafter.** After 3 missed appointments or cancelled appointments you may be subject to double booking or a short call list. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours. In addition, we require appointments to be confirmed by patient NO LATER THAN 24 hours prior to appointment time. If appointments remain unconfirmed less than 24 hours before start of the appointment, they are subject to forfeit.

PLEASE INITIAL HERE TO VERIFY YOU HAVE READ AND UNDERSTAND THE APPOINTMENT POLICIES: _____

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we will need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January – December). We also need to be informed promptly of any change in insurance coverage during the year.

All of our doctors will diagnose treatment based on your dental health not your insurance coverage.

You must realize that: Dental insurance provides limited coverage. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of benefit and how much the premium costs per month. Most benefit plans are designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay, however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling. Consider your insurance more like a rebate or coupon. It provides assistance.

Completion of treatment implies acceptance and consent on your part to the treatment. Any balance not paid by the insurance company is the responsibility of the patient to pay.

If your insurance has not paid within 90 days of services rendered, we require you to make full payment to this office and be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries.

The insured has a better ability to deal with the insurance company and the employer responsible for the policy.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

_____

Patient's name (please print)

_____

Patient's signature **Date**

Dr. Kimberly Ford
Ellicott Mills Dental
410-461-3311
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3505 Ellicott Mills Drive, Suite B2
Ellicott City, MD 21043

ELLICOTT MILLS DENTAL

HIPAA AUTHORIZATION

For this page, if you wish for anyone (spouse, child, parent, etc.) to speak with the office regarding any aspect of your account (balances, appointments, scheduling, etc.) they must be listed below.

If there isn't anyone you wish to authorize, please write "N/A" then sign and date. Thank You!

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

_____
Signature of Patient (Or Legal Guardian)

_____
Printed Name of Patient (Or Legal Guardian)

_____
Today's Date

Dr. Kimberly Ford
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