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? _____

What type of toothbrush do you use? HANDHELD _____ELECTRIC_____

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

Do your gums bleed when you brush? _____

Are your 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? _____

MEDICAL HISTORY

PLEASE FILL OUT BOTH PAGES, SIGN AND DATE

Name: _____ Date of Birth: _____

Physician's name and phone number: _____

Date of last physical examination: _____

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

_____

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 an oral sleep appliance?_____ 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 CARDIOCASCULAR

___ ___ HIGH BLOOD PRESSURE
___ ___ ANGINA
___ ___ HEART ATTACK
___ ___ STROKE
___ ___ ARTIFICIAL HEART VALVE
___ ___ ATRIAL FIBRILLATION (AFIB)
___ ___ HYPERLIPIDEMA (HIGH CHOLESTEROL)
___ ___ STENTS (HEART)
___ ___ BACTERIAL ENDOCARDITIS

YES NO ENDOCRINE

___ ___ DIABETES
IF YES, A1C LEVEL_____
___ ___ THYROID DISEASE

YES NO RESPIRATORY

___ ___ ASTHMA
___ ___ EMPHYSEMA
___ ___ TUBERCULOSIS
___ ___ COPD

YES NO IMMUNOLOGICAL

___ ___ AUTOIMMUNE DISEASE
___ ___ HIV/AIDS
___ ___ ARTHRITIS
___ ___ LUPUS
___ ___ SJOGREN'S SYNDROME

YES NO MUSCULOSKELETAL

___ ___ FIBROMYALGIA
___ ___ OSTEOPOROSIS
___ ___ ARTIFICIAL JOINTS

YES NO HEMATOLOGIC

___ ___ ANEMIA
___ ___ SICKLE CELL DISEASE
___ ___ CLOTTING DISORDER
___ ___ DIALYSIS

YES NO GASTROINTESTINAL

___ ___ ACID REFLUX/GERD
___ ___ IRRITABLE BOWEL DISEASE
___ ___ STOMACH ULCERS

YES NO HEPATIC (LIVER)

___ ___ CIRRHOSIS
___ ___ HEPATITIS
___ A
___ B
___ C
___ ___ JAUNDICE

YES NO NEUROLOGICAL

___ ___ EPILEPSY/SEIZURES
___ ___ PARKINSON'S DISEASE
___ ___ MULTIPLE SCLEROSIS
___ ___ STENTS (NEURO)

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
Ellicott Mills Dental

Welcome! Thank you for selecting us as your dental health care provider. 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:

Patients are expected to pay for services on the day of treatment. If you have dental insurance, you are expected to pay the amount of your estimated co-pay and deductible on the day of treatment. Payments may be made using cash, check, Visa, MasterCard, Discover, or American Express. (**Card transactions are subject to a 2.75% surcharge**). If you do not have dental insurance, then it is your responsibility to pay the full cost at the time of treatment, unless otherwise discussed with your treating dentist.

Ellicott Mills Dental will send monthly statements to all patients with an outstanding balance to the billing location of your choosing—either electronically or via paper mail.

CHERRY PAYMENT PLANS:

Alternatively, we happily accept **Cherry Payment Plans**, which are flexible payment plans with no hard credit checks and no effect to your credit score. Cherry plans range from 6 weeks to 60 months, with approvals up to $50,000 with a 60 second application. Applications **must** be submitted using our office's direct link:

www.pay.withcherry.com/ellicott-mills-dental
(This link can be emailed or texted to you at your request)

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

Broken & Missed Appointment Policy:

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 two business days' notice for any cancellation or change of appointment. If two business days' notice is not given, there will be a $50 charge per standard appointment time (60 minutes) with an extra $25 per additional half hour (30 minutes) scheduled thereafter. After 3 missed 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 the patient NO LATER THAN 24 hours prior to appointment time. If appointments remain unconfirmed less than 24 hours before the start of the appointment, they are subject to forfeit.

Any change of appointment (cancel, re-schedule, postponement, etc.) must be made via phone call directly with the office (410-461-3311). Please do not cancel via text message or email to ensure that your message is received.

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

_____

FINANCIAL POLICY
Ellicott Mills Dental

Insurance Information:

Our doctors will diagnose treatment based on your dental health not your insurance coverage. 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. To effectively do this, we need your current insurance card (front and back) at least one week prior to your scheduled appointment. We also need to be informed promptly of any change in insurance coverage during the year.

Please realize that dental insurance provides limited coverage. Typically, it is a financial benefit, usually provided by an employer, to help their employees pay for routine dental services. The employer chooses 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, not the entire treatment amount. 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 is called an insurance downgrade). 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 payment 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 for pursuing payment from the insurance company. All current documentation will be provided by mail to assist with your inquiries.

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

We are happy to provide a copy of this policy for you to keep upon request.

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
Ellicott Mills Dental
410-461-3311
ellicottmillsdental.com
3505 Ellicott Mills Drive, Suite B2
Ellicott City, MD 21043

ELLICOTT MILLS DENTAL

Consent For Electronic Billing

Patient Name: _____

Date of Birth: _____

By signing this document, I consent to receive electronic billing statements from Ellicott Mills Dental. I would like my statements and balances sent to me at the below locations:

Email Address: _____

Cell Phone #: _____

I acknowledge that by providing this consent, I will only receive statements electronically and not on paper via mail. (**Please sign and date below**)

or

_____ I wish to decline electronic billing and only receive paper statements via mail.

Patient Signature: _____

Today's Date: _____

Please note: A physical signature is required on this document; we cannot accept a typed name. Thank you.

Dr. Kimberly Ford
Ellicott Mills Dental

410-461-3311
ellicottmillsdental.com

3505 Ellicott Mills Drive, Suite B2
Ellicott City, MD 21043