THURMONT SMILES
Advanced Family Dentistry

PATIENT REGISTRATION

Date: _____

First Name: _____ M.I. ___ Last Name: _____ ☐ male ☐ female Date of Birth: _____ Age: ____
(Enter as MM/DD/YYYY)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security #: _____
(Do NOT include dashes or spaces)

Email Address: _____ Emergency Contact: _____

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Have you seen us on: ☐ Facebook ☐ Twitter ☐ YouTube ☐ Google Reviews ☐ Television ☐ Local Magazine ☐ Newspaper

PRIMARY INSURANCE POLICY

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Sub. ID#: _____ Sub. DOB: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

SECONDARY INSURANCE POLICY

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Sub. ID#: _____ Sub. DOB: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

AUTHORIZATION

I attest that I understand and answered all the above questions honestly and completely. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Thurmont Smiles unless otherwise indicated.

Name of Parent/Guardian: _____
(If patient is a minor)
Relationship to Patient: _____

Patient/Guardian Signature Date:

First Name: _____ Last Name: _____ Date of Birth: _____

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MEDICAL HISTORY

Tooth Shade:

Today's BP _____/_____

Physician's Name: _____ Phone Number: _____

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) Y (Yes) or N (No) if you have or have had any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Cortisone Treatments	☐	☐	Jaw Pain	☐	☐	Sleep Apnea
☐	☐	Arthritis, Rheumatism	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Snoring
☐	☐	Artificial Devices or Joints	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Stomach Ulcers/GERD/ Acid Reflux
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Nervous System Problems	☐	☐	Stroke
☐	☐	Autoimmune Conditions	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐	Swelling Feet /Ankles
☐	☐	Bleeding Problems	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Heart Problems	☐	☐	Psychiatric Treatment	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Heart Surgery	☐	☐	Radiation Treatment	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Hepatitis	☐	☐	Respiratory Disease			
☐	☐	Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath			
☐	☐	Circulatory Problems	☐	☐	HIV/AIDS	☐	☐	Skin Rash			
☐	☐	OTHER: _____									

MEDICATIONS

List of medications you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Pharmacy: _____ Phone: _____

ALLERGIES

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Local Anesthetic
☐	☐	Barbiturates (sleeping pills)	☐	☐	Penicillin
☐	☐	Codeine/Narcotics	☐	☐	Sulfa
☐	☐	Latex			
☐	☐	OTHER: _____			

AUTHORIZATION

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms as well as releasing Dr. Oza to utilize any dental photographs for lecturing, educational, marketing purposes.

Name of Parent/Guardian: _____
(If patient is a minor)
Relationship to Patient: _____

Patient/Guardian Signature Date:

Doctor Signature Date:

First Name: _____ Last Name: _____ Date of Birth: _____

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DENTAL HEALTH AND HISTORY

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐Yes ☐No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? ____ time(s) a _____ How often do you floss? ____ time(s) a _____

What type of brush do you use? ☐Manual ☐Powered

Do you avoid brushing any part of your mouth because of pain? ☐Yes ☐No If yes, what part? _____

Which foods cause you twinges of pain: ☐Hot ☐Cold ☐Sweet ☐Sour ☐None

Do your gums feel tender or swollen? ☐Yes ☐No

Do you chew on only one side of your mouth? ☐Yes ☐No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ☐Yes ☐No Do your jaws ever feel tired? ☐Yes ☐No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? ☐Yes ☐No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): _____

Would you like to have whiter teeth? ☐Yes ☐No

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Would you like to see what YOU would look like with a new and improved smile? ☐Yes ☐No **If yes, please select all that apply:**

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

At Thurmont Smiles, we are committed to provide you with exceptional, gentle dental care. We consider you family. Utilizing state of the art technology, we will work with you to give you healthy and beautiful smile you desire and deserve.
Thank you so much for the opportunity to be of service to you!

With warm regards,
Mansi Oza, BDS, DMD

First Name: _____ Last Name: _____ Date of Birth: _____

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FINANCIAL POLICY

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals,we need your assistance and your understanding of our payment policy. For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

A) Split Payment
Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/ bridges/veneers.

B) Pay as You Go
You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) Prepayment in Full
For any treatment over $2000, a prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

D) CareCredit
Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no up front costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

Interest of 1.5% per month will be charged on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can.

I understand that if I become delinquent on my account, my account will be turned over to a collection agency and I will subsequently be reported to the credit bureaus. In case of total default I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

After your dental insurance has paid for dental services rendered at Thurmont Smiles, you may have an outstanding balance.
This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe.
For balance owed, we will require a credit card authorization, or you may need to pay your entire balance up-front.

Credit Card: (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex ☐ CareCredit

Card #: _____ Expiration Date: _____ CVV #: _____
(Do NOT include dashes or spaces) *(Enter as MMYY)*

Card Holder Signature: _____

Billing Address: _____ State: ____ Zip: _____

I certify that I have read, fully understand, and accept the above financial policy.

Name of Parent/Guardian: _____
(If patient is a minor)
Relationship to Patient: _____

Patient/Guardian Signature Date:

First Name: _____ Last Name: _____ Date of Birth: _____

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INFORMATION REGARDING BISPHOSPHONATES

Bisphosphonates are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as for a disorder called Paget's disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24th, 2004.

It is very important for you to let us know if you are now, or have ever taken in the past, ANY type of bisphosphonate class drug. If we treat you without knowing if you are now taking, or have taken in the past, any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we must know if you have ever taken any of them. Brand names of these drugs include (but may not be limited to) are:

- **Fosamax**
- **Zometa**
- **Aredia**
- **Actonel**
- **Boniva**
- **Bonefos**
- **Skelid**
- **Didronel**

Are you now, or have you in the past, taken a bisphosphonate drug, including any of the brands above?

☐ YES ☐ NO DATE _____

INFORMATION ON THE ELECTION OF TREATMENT OPTIONS

Your dentist will design a treatment plan in which he/she will recommend that you undergo specific dental procedures. You will be presented with the optimum treatment for your particular dental needs. If, in the dentist's judgment, other acceptable treatment options exist, these will be discussed with you as well. There are likely to be increased risks and potential complications should you elect to have an alternative form of treatment that differs from the optimum treatment plan presented to you. Please discuss these issues in more detail with your dentist. Be sure to understand the potential risks and complications before consenting to treatment.

Name of Parent/Guardian: _____
(If patient is a minor)
Relationship to Patient: _____

Name of Witness: _____

Patient/Guardian Signature Date:

Witness Signature Date:

First Name: _____ Last Name: _____ Date of Birth: _____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, DENTAL & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Work Phone Confirmation ☐ Email Confirmation
☐ Home Phone Confirmation ☐ Text Message to my Cell Phone ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Work Phone Confirmation ☐ Email Confirmation
☐ Home Phone Confirmation ☐ Text Message to my Cell Phone ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

☐ Phone Message ☐ Email ☐ **None of the above** (opt out)
☐ Text Message ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Name of Parent/Guardian: _____
(If patient is a minor)
Relationship to Patient: _____

Your comments regarding Acknowledgements or Consents:

_____

_____

Patient/Guardian Signature Date:

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment
☐ I could not communicate with the patient
☐ The patient refused to sign
☐ The patient was unable to sign because _____
☐ Other (please describe)

_____

Privacy Officer: _____

First Name: _____ Last Name: _____ Date of Birth: _____

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APPOINTMENT AGREEMENT

At Thurmont Smiles, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 48 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 business hours, you will be subject to a $50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at Thurmont Smiles and agree to the "broken appointment" fee should I not give proper notification.

Name of Parent/Guardian: _____
(If patient is a minor)
Relationship to Patient: _____

Patient/Guardian Signature Date:

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