Hunt Valley Dental Welcomes You!

Patient's Name____
Last First Middle Initial Nickname

Address ____
Street City State Zip

Home Phone _____________ **Work Phone** ________________ **Cell Phone** __________________

Date of Birth _____________ **Age** ________ **Social Security #** __________________

Male ___ **Female** ___ **Gender Neutral** ___

Single____ **Married** ____**Separated** ____**Widowed** ___**Divorced** ___

Emergency Contact with phone number ____

Employer_____________________________________**Occupation**________________________

Employer's Address________________________**City**_______________**State**_____**Zipcode**______

Email ___________________________

How would you prefer that we contact you to confirm appointments? Please check preferences:

Home Phone ____ **Work Phone** ____**Cell Phone** ____ **Email** ____ **Text to Cell** ____

How did you hear about us? _______________________

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name ___________________________ **D.O.B**____________ **SS#**__________________

Insured's Employer (if different than listed above) ____

Dental Insurance Company_____________________________________ **Policy #**_______________

Dental Insurance Company Address____

I hereby authorize payment directly to Hunt Valley Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. Any overdue payments are subject to a 12% finance charge. In the event my account is turned over to a third party for collection, I will be responsible for all fees.

I hereby authorize Hunt Valley Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature ____ **Date** ____________________

THANK YOU FOR ALLOWING US TO SERVE YOU!

HUNT VALLEY DENTAL HEALTH HISTORY

Name ____ Date ______________________________

Date of last health care exam: ________________What was this exam for?__________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:____

Are you currently receiving care? No Yes If yes, nature of care: __________________________

____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart (Surgery, Disease, Attack)	No	Yes	Joint Replacement	No	Yes
Stroke	No	Yes	Pacemaker	No	Yes
Abnormal Blood Pressure	No	Yes	Migraines or frequent headaches	No	Yes
Epilepsy	No	Yes	Parkinson's Disease	No	Yes
Hepatitis, Any Form	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Abnormal Bleeding from a cut	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Anxiety, Depression or any other Mental Condition	No	Yes
Alzheimer's/Dementia	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Cancer	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	Nerve/Muscle Disease	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal supplements?	No	Yes
Have you been treated with Fosamax, Actonel, Boniva or Reclast?				No	Yes

Please list any medications you are currently taking:

1. ________________________________ 2. ________________________________
3. ________________________________ 4. ________________________________
5. ________________________________ 6. ________________________________

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

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Health History – Page 2

Are you allergic or have you had a reaction to: Name of Medication

a. Local anesthetics ……………………… No Yes ______________________________

b. Penicillin or other antibiotics ………… No Yes ______________________________

c. Aspirin or over the counter medications No Yes ______________________________

d. Codeine, valium, or other sedatives…… No Yes ______________________________

Any Other Medication: ____

Do you snore or have Sleep Apnea? No Yes

Are you allergic to Latex? No Yes

Are you a smoker? No Yes

If so, how much do you smoke per day? _______________

Have you ever been addicted to any substance or drug? No Yes

If Yes, What were you addicted to? ___________________ During what time period? ________________

Any other health situation we should know about?______________________________________

For patients interested in sedation:

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Diet: Restricted Diet __________________________ Weight: __________

How many meals a day ______________________

Food Allergies __________________________

Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

Ii understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

______________________ ______________________ ______________

Patient (Print Name) *Patient Signature* *Date*

____

Doctor Signature and Date

HUNT VALLEY DENTAL
We would like to get to know you!

Please take a moment to answer the following questions. Accurate answers will allow us to treat you on a more individual basis, providing the care appropriate for your needs. Your responses are for our records only and will be considered confidential. Your health and comfort are of the utmost concern to us.

Name____Date__________________

1. **Does dental treatment make you nervous? No____ Slightly____Moderately____Extremely_____**
2. **Why did you leave your previous dentist? ____**
3. **On a scale of 1-10, with 10 being the highest rating:**

   How important is your dental health to you?

   1 2 3 4 5 6 7 8 9 10

   Where would you rate your current dental health?

   1 2 3 4 5 6 7 8 9 10

4. **Do you get cold sores Yes____No____ How often?_____________________________**
5. **Do you have, or have you ever had, any of the following:**

MOUTH		**TEETH**	
Bleeding, sore gums	**Yes____No____**	**Loose teeth**	**Yes____No____**
Unpleasant taste/bad breath	**Yes____No____**	**Sensitive to hot**	**Yes____No____**
Swelling/lumps in mouth	**Yes____No____**	**Sensitive to cold**	**Yes____No____**
Orthodontic treatment (braces)	**Yes____No____**	**Sensitive to chewing**	**Yes____No____**
Clicking/popping jaw	**Yes____No____**	**Food packing between teeth**	**Yes____No____**
Difficulty opening or closing jaw	**Yes____No____**	**Clenching/grinding**	**Yes____No____**

6. **Please share the following dates:**
   Your last cleaning _____/_____ Your last complete X-Rays _____/_____
7. **Do you have any fears or questions about dental care? ______________________________________**

____

10. **Is there anything that concerns you about the appearance of your teeth? ___________________________**

____

12. **Is there anything we can do to make your visit with us more enjoyable?___________________________**

____

<u>Thanks for helping us to better serve you!</u>

Financial Guidelines

Thank you for choosing Hunt Valley Dental as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand payment of your bill is considered part of your treatment. Payment is due at the time service is provided. **A 10% deposit is required when scheduling appointments 1 ½ hrs or longer in length.** Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options: ☐

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred up to 35%.

Do you have insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and any documents that may be required by your insurance company.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. We cannot, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial guidelines.

Consent:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. The undersigned hereby authorized Dr. Rhodes to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Rhodes to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Rhodes to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, or attorney fee will be added to any overdue balance.

Patient Signature (Parent of Child if dependant)________________________________Date:_______________

Hunt Valley Dental Notice of Privacy Practices

Patient's Acknowledgment Form

I, ____________________, acknowledge that I received and reviewed the office Privacy Policy Notice for Hunt Valley Dental.

Patient's Signature: _____________________________ Date:___________________

In case you do not agree to sign this form, our office must indicate why you declined to do so.
Reason for patient's refusal:
____
____
____

Privacy Director's Signature:_______________________ Date:____________________