



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 _____ Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

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 _____ Phone # _____

Dental Insurance Company Address _____

Do you have Secondary Dental Insurance? If so, please provide information on the back of this form.

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 Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	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. _____ |

Do you have Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: _____

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

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

I 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'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Thomas W Rhodes DMD _____
Doctor (Print Name) Doctor Signature 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?

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

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? _____

Thanks for helping us to better serve you!



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: _____