Hunt Valley Dental Welcomes You!

Please take a moment to provide the following information. The more we know about your child, the better we'll be able to serve you. Your child's health and comfort are of the utmost concern to us.

Patient's Name____Nickname___________________________

Residence Address______________________________City___________________State_____Zipcode_________

Home Phone _______________ **Male** ____ **Female** ____ **Date of Birth** ___________ **SSN**________________

How long has it been since your child has seen a dentist? ________________

Does your child have an allergic reaction to latex? _____ **Does dental treatment make your child nervous?** _____

Parent's name____ **Cell Phone** _________________________________

Home Phone __________________**Work Phone** _______________________**E-Mail**__________________________

Date of Birth __________________**Age**____________ **Social Security #**_________________________

Male _____ **Female** _____ **Single** _____ **Married** _____ **Separated** _____ **Widowed** _____ **Divorced** _____

Employer____**Occupation**_______________________________

Employer's Address_______________________________**City**___________________**State**______**Zipcode**________

Whom may we thank for this referral? ____________________

<u>DENTAL INSURANCE INFORMATION</u>

Insured's Name____________________________________ **Date of Birth**____________ **SS#**__________________

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

Employer's Address____________________________________**City**_______________**State**_____**Zipcode**_______

Dental Insurance Company ____**Phone #**_____________________

Dental Insurance Company Address____

Effective Date of Dental Insurance: ____________________

If the parents are separated or divorced, the parent bringing the child to our office must be the responsible party for financial matters.

To the best of my knowledge, the above answers are true and correct. I will inform your office of any changes at the next appointment. **Signature**__________________________ **Date**________________

THANK YOU FOR ALLOWING US TO SERVE YOU!

THERE IS A FEE FOR APPOINTMENTS CANCELLED WITH LESS THEN 24 HOURS NOTICE

MEDICAL HISTORY

Name ____

Physician's Name ____

Is the patient under a physician's care now?…❑Yes ❑ No Reason for Treatment____________________

*Has the patient ever been hospitalized for any serious illness or for any surgical procedure? If yes, please describe*____

Is the patient taking any medications, including over the counter medications?……………..❑Yes ❑ No

If yes, please list medications____

Is the patient allergic to or have you had any reaction to specific medications?……………..❑Yes ❑ No

If yes, please list medications____

Does the patient use any tobacco products?_____________________How Much?______________________

***Women Only**: Is the patient pregnant, or do you think they may be pregnant?………… ❑Yes ❑ No*

Are they Nursing? ……… ❑Yes ❑ No Are they taking Birth Control pills?…. ❑Yes ❑ No

Does the patient have or have they ever had any of the following:

Heart Attack……………….. ❑Yes ❑ No
Heart Disease……………… ❑Yes ❑ No
High Blood Pressure……….. ❑Yes ❑ No
Low Blood Pressure……….. ❑Yes ❑ No
Rheumatic Fever…………... ❑Yes ❑ No
Scarlet Fever……………….. ❑Yes ❑ No
Heart Murmur………….…… ❑Yes ❑ No
Diabetes…………………..…… ❑Yes ❑ No
Kidney problems…………… ❑Yes ❑ No
Arthritis/Rheumatism………. ❑Yes ❑ No
Joint Replacement………….. ❑Yes ❑ No
Hay Fever/Sinus Problems…. ❑Yes ❑ No

Epilepsy/Seizures…………. ❑Yes ❑ No
TB or Lung Disease………. ❑Yes ❑ No
Cancer……………………… ❑Yes ❑ No
Radiation Treatment………. ❑Yes ❑ No
Migraines…………………… ❑Yes ❑ No
Anemia…………………….. ❑Yes ❑ No
Abnormal Bleeding………… ❑Yes ❑ No
Hepatitis……………………. ❑Yes ❑ No
Liver disease……………..…. ❑Yes ❑ No
Stroke……………………..…. ❑Yes ❑ No
Glaucoma…………………..… ❑Yes ❑ No
HIV / AIDS………………… ❑Yes ❑ No

Any other health situation we should know about? ____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including diagnosis and the records of any treatment rendered to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

Patient' Signature (Parent if Minor)____

Doctor's Signature____________________________________Date_________________________

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. 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 or a credit card 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. The Privacy Notice is available to read at www.AdvancedDentistryBaltimore.com

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:_____________________