CHERRYWOOD DENTAL ASSOCIATES

# PATIENT REGISTRATION

**Today's Date: _____**

Patients Name_____

Sex: M F Birthdate_____Age_____

Home Address_____City_____State_____Zip_____

Please Your Soc. Sec. #_____-_____-_____ Circle One: Single Married Separated Widow

Home Ph. #_____ Cell Ph. #_____ Email: _____

Employer_____ Ph. # _____ Time Employed_____

Are you a full time student? ☐ Yes ☐ No *If patient is minor*: Mother's DOB _____Father's DOB _____

Person responsible for account _____Driver's License#_____ Relationship_____

Name of spouse (parent if minor) _____ Spouse's (parent's) Sec. Sec. #) _____-_____-_____

Spouse's (parent's) Employer _____ Work Ph. #_____ Cell Ph.#_____

EMERGENCY INFORMATION- *Name, address, & telephone of a relative not living with you*

_____

Reason for this visit_____

How did you hear about our office?_____

**DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)**

Insured's Name_____

Insured's Employer_____

Insurance Co_____

Insurance Co Address_____

Phone # _____DOB_____

SS#_____-_____-_____

Group #_____ Local # _____

Patient's Name_____

## DENTAL HISTORY

| | Yes | No |
|---|---|---|
| Please check any of the following problems That apply to you | | |
| -Sensitivity (hot; cold; sweet; pressure) | ☐ | ☐ |
| Where? UR LR UL LL | | |
| -Headaches, earaches, neck pain | ☐ | ☐ |
| -Jaw Joint Pain | ☐ | ☐ |
| -Teeth or Fillings breaking | ☐ | ☐ |
| - Grinding or clenching teeth | ☐ | ☐ |
| -Bleeding, swollen or irritated gums | ☐ | ☐ |
| -Loose, tipped or shifting teeth | ☐ | ☐ |
| -Bad breath | ☐ | ☐ |
| Do you have or have you had any of the following? | | |
| -Dentures | ☐ | ☐ |
| -Partial Dentures | ☐ | ☐ |
| -Braces | ☐ | ☐ |
| -Periodontal ( gum ) treatments | ☐ | ☐ |

Share the following dates:

-Your last cleaning ____ / ____

-Your last oral cancer screening ____ / ____

-Your last complete X-rays ____ / ____

Name of Previous Dentist _____

City_____ State_____

Phone Number _____

| | Yes | No |
|---|---|---|
| If you could whiten your teeth for a cost anyone could afford, would you do it? | ☐ | ☐ |
| Do you smoke or use chewing tobacco? | ☐ | ☐ |
| How much _____ For how long?_____ | | |
| If I could change my smile, I would: | | |
| -Make it whiter | ☐ | ☐ |
| -Make it straighter | ☐ | ☐ |
| -Close spaces | ☐ | ☐ |
| -Replace black metal fillings with tooth colored restorations | ☐ | ☐ |
| -Repair chipped teeth | ☐ | ☐ |
| -Replace missing teeth | ☐ | ☐ |
| -Replace old crowns that don't match | ☐ | ☐ |
| -Have a smile makeover | ☐ | ☐ |

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

Where do you want your health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

_____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

## MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS | ☐ | ☐ | Dizziness | ☐ | ☐ | HIV Positive | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Allergies (Seasonal) | ☐ | ☐ | Drug Addiction | ☐ | ☐ | HPV (Human Papilloma Virus) | ☐ | ☐ | Seizures | ☐ | ☐ |
| Anemia | ☐ | ☐ | Emphysema | ☐ | ☐ | Jaundice | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Angina (Chest pain) | ☐ | ☐ | Epilepsy | ☐ | ☐ | Jaw Joint Pain | ☐ | ☐ | Sleep Apnea | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stomach Problems | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Fainting | ☐ | ☐ | Liver Disease | ☐ | ☐ | Stroke | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Glaucoma | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Conditions | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | Heart Lesions | ☐ | ☐ | Nervousness/ Depression | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Bruise Easily | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Pacemaker | ☐ | ☐ | Venereal Diseases | ☐ | ☐ |
| Cancer | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Pregnant Currently | ☐ | ☐ | Other | ☐ | ☐ |
| Cervical Cancer | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Radiation (head/neck) | ☐ | ☐ | _____ | | |
| Chemotherapy | ☐ | ☐ | Hepatitis B | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | _____ | | |
| Cortison Medication | ☐ | ☐ | Hepatitis C | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | _____ | | |
| Diabetes | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Rheumatism | ☐ | ☐ | _____ | | |

Are you allergic or have you reacted adversely to any of the following medications?

| | Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aspirin | ☐ | ☐ | Percodan | ☐ | ☐ | Tetracycline | ☐ | ☐ | Valium | ☐ | ☐ | Other _____ |
| Darvon | ☐ | ☐ | Latex | ☐ | ☐ | Codeine | ☐ | ☐ | Penicillin | ☐ | ☐ | _____ |
| Nitrous Oxide | ☐ | ☐ | Local Anesthetic | ☐ | ☐ | Erythromycin | ☐ | ☐ | Sulfa | ☐ | ☐ | _____ |

Have you ever taken any of the following medications?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Actonel | ☐ | ☐ | Zometa | ☐ | ☐ |
| Aredia | ☐ | ☐ | Boniva | ☐ | ☐ |
| Fosamax | ☐ | ☐ | Herbal | ☐ | ☐ |
| Reclast | ☐ | ☐ | Supplments | | |

Are you under a physician's care? What for? _____

What Medications are you currently taking? _____

Family Physician_____ Phone Number _____

*Consent:*

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor 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 have read, understand and agree to the above terms and conditions.

_____ _____ _____

**Patient Signature (Parent if child)** **Date** **Dentist's Signature**

**FINANCIAL POLICY**

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due prior to scheduling. Our office accepts cash, MasterCard, Visa, Discover, and American Express. 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 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/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

• We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, MasterCard, Visa, Discover, American Express or available financing prior to scheduling.

• 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. Our office will not, 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 policy.

***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. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable prior to scheduling unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____

**Patient Signature** (Parent if child) **Date**

5510 Cherrywood Lane Greenbelt, Maryland 20770 T: (301) 982-3300 F: (301) 345-1224

13895 Hedgewood Drive Ste. 237 Woodbridge, Virginia 22193 T: (703) 565-5078 F: (703) 565-5084

# Cherrywood Dental Associates

## NOTICE OF PRIVACY PRACTICES

**THIS NOTE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while is in effect. This Notice takes effect on 07/16/2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created of received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**TREATMENT:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operation include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse of Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

# ACKNOWLEDGEMENT OF RECEIPT OF

# NOTICE OF PRIVACY PRACTICES

I, _____, have read the Notice of Privacy Practices.

_____ _____

Signature Date

**NOTE:**

**To cancel your appointment, it is necessary that you call and notify us at least 48 hours in advance before your appointment date to prevent a $50.00 cancellation fee. Thank you in advance for your cooperation.**

**_____ _____**

**Patient Signature** **Date**