SENECA DENTAL CARE

Erica Ford, DDS
20 Executive Park Court
Germantown, MD 20874
301-916-5800

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Patient Name: Last _____ First_____ M.I. _____
Address: Street_____City_____State_____Zip_____
Email: _____
Phone Number: _____ □ Home □ Cell □Office
Phone Number: _____ □ Home □ Cell □Office
Phone Number: _____ □ Home □ Cell □Office
Birthdate: _____ Sex (for insurance): _____
Social Security Number _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name: Last _____First_____M.I._____ Marital Status: _____
Address: Street_____City_____State_____Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____ Email:_____
Relationship to Patient: _____ Birthdate of Policyholder:_____
Social Security Number: _____

EMERGENCY CONTACT

Name: _____ Relationship:_____
Phone Number: _____ □ Home □ Cell □Office

HEALTH HISTORY

Physician's Name: **Office Phone:** **Date of Last Visit:**

Please check if you have/had any of the following:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
AIDS/HIV			Epilepsy			Radiation Treatment		
Anemia			Fainting or dizziness			Respiratory Disease		
Arthritis, Rheumatism			Glaucoma			Rheumatic Fever		
Artificial Heart Valves			Headaches			Scarlet Fever		
Artificial Joints			Heart Murmur			Shortness of Breath		
Asthma			Heart Problems			Sinus Trouble		
Back Problems			Hepatitis Type			Skin Rash		
Bleeding abnormally, with extractions or surgery			Herpes			Special Diet		
Blood Disease			High Blood Pressure			Stroke		
Cancer			Jaundice			Swollen Feet or Ankles		
Chemical Dependency			Jaw Pain			Swollen Neck Glands		
Chemotherapy			Kidney Disease			Thyroid Problems		
Circulatory Problems			Liver Disease			Tonsillitis		
Congenital Heart Lesions			Low Blood Pressure			Tuberculosis		
Cortisone Treatments			Mitral Valve Prolapse			Tumor or growth on head or neck		
Cough, persistent or bloody			Nervous System Problems			Ulcer		
Diabetes			Pacemaker			Venereal Disease		
Emphysema			Psychiatric Care			Weight Loss, unexplained		
Women: Are you pregnant?			Are you nursing?			Taking birth control pills		

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DENTAL HISTORY

Previous Dentist: _____ **Date of Last Exam:** _____
Reason for today's visit _____
How often do you brush? _____ **How often do you floss?** _____

Please check if you have/had any of the following:	Yes	No		Yes	No		Yes	No
Bad breath			Fingernail biting			Mouth pain with brushing		
Bleeding gums			Food collection between teeth			Orthodontic treatment		
Blisters on lips or mouth			Foreign objects			Pain around ear		
Burning sensation on tongue			Grinding teeth			Periodontal treatment		
Chew on one side of mouth			Gums swollen or tender			Sensitivity to cold/hot		
Cigarette, pipe, or cigar smoking			Jaw pain or tiredness			Sensitivity to sweet/sour		
Clicking or popping jaw			Lip or cheek biting			Sensitivity when biting		
Dry mouth			Loose teeth or broken fillings			Sores/growth in mouth		
E-cigarette/Vaping			Mouth breathing			Other		

ALLERGIES/ MEDICATIONS/MEDICAL PROCEDURES

IF NO ALLERGIES, PLEASE CHECK THIS BOX - ☐

Please check if you have/had allergies to any of the following:	Yes			Yes			Yes
Aspirin			Latex			Other (Please describe)	
Barbiturates (Sleeping pills)			Local Anesthetic			_____	
Codeine			Penicillin			_____	
Iodine			Sulfa				

List any medications you are currently taking and the reason (Please use additional sheets, if necessary):

List any surgeries or other major medical procedures:

_____
_____
_____
_____

AUTHORIZATION AND RELEASE

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate 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 that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am ultimately responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me, if I have paid the dental fees incurred. I further understand that a late charge may be added to any overdue balance. If legal action becomes necessary to collect fees due to the office, the undersigned agrees to pay all reasonable costs of such action including attorney's fees and collection costs. There may be a broken appointment fee if 48-hour notice is not given to reschedule or cancel an appointment.

_____ _____
Signature of Patient (Parent/Guardian) Date

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for Seneca Dental Care. The Statement of Privacy describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the facility.

Seneca Dental Care reserves the right to change the privacy practices that are described in the statement of Privacy Practices. If privacy practices change, you will be offered a copy of the revised Statement of Privacy Practices. At the time of your first visit after the revisions become effective. You may also obtain a copy of the Statement of Privacy Practices by requesting one to be mailed to you.

ADDITIONAL DISCLOSURE AUTHORITY

Patient Name (Please Print):_____

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the persons indicated below:

Please Check:

☐ Any Member of My Immediate Family ☐ Spouse Only

☐Other Please Specify _____

_____ _____
Signature of Patient (Parent/Guardian) Date

Broken Appointment and Cancellation Policy Consent

We require 48 hour advance notice when canceling an appointment that has been reserved for you. If you fail to abide by the 48-hour rule, you will be charged a $100 missed appointment fee.

Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for 2 appointments in a 6-month time span may result in DISMISSAL form Seneca Dental Care.

I acknowledge that I have been informed of the broken appointment and cancelation policy held by Seneca Dental Care. I have read the above policy and agree to abide by it.

_____ _____
Signature of Patient (Parent/Guardian) Date

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General Consent for Treatment

I hereby consent to the performance of dental treatment upon **myself and/or my dependents** by Seneca Dental Care. Such treatment will be explained to me and will not proceed without my acceptance. I reserve the right to ask specific questions before recommended treatment commences. The nature and purpose of the treatment rendered, possible hazards, and alternative methods of treatment will be fully explained to me. I understand the risk involved with treatment. No guarantee, warranty, or insurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of Seneca Dental Care.

Photographs:
Seneca Dental Care may request photographs to be taken for certain procedures. These photographs are for insurance, laboratory, patient education, and advertising purposes. Photographs will not be taken without verbal consent from the patient. All photographs and/or duplications are property of Seneca Dental Care.

Who may we thank for referring you to our practice?

☐ Website ☐ Insurance Company ☐ Community Event ☐ Other _____

Name of person or office referring you to our practice _____

Agreement to Receive Electronic Communication

Patient Name:_____ **Date of Birth:**_____

I agree that the dental practice may communicate with me electronically at the email address and/or texting below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling: **301-916-5800. Standard message and data rates will apply.**

Email Address:_____

Cell Phone Number (for texting notifications):_____

_____ _____
Signature of Patient (Parent/Guardian) Date

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Financial & Insurance Policies

We are pleased that you have chosen our practice for your dental care. Our goal is not only to treat you, but also to educate you on how to prevent dental disease. Our mission is to provide you with the highest quality dental care in a pleasant surrounding and as efficiently possible. Please read and sign the following policies.

Insurance Policies

- Insurance companies do not cover 100% of all dental expenses. It is your responsibility to be familiar with restrictions, limitations, and deductions that may apply to your plan. Your portion not covered by insurance is due at the time treatment is rendered. Please understand that dental insurance is a contract between you and your insurance carrier. You are still the responsible party regarding dental treatment fees; as a courtesy to you we will submit claims to your insurance company for you.
- All deductibles and copayments must be satisfied at the time treatment is rendered. Please understand that the requested amount of copayment or coinsurance is **approximated** based on the information received from your insurance company. All claims that are rejected or adjusted by the insurance company will become your additional responsibility and payable to Seneca Dental Care immediately.
- If Seneca Dental Care is not participating with your insurance, payment is expected in full at the time of service unless prior arrangements have been made. We will provide you with a statement of services rendered to submit to your insurance carrier once the balance is paid in full.
- All insurance claims not paid within 60 days of submission to the insurance company are due and payable by the patient.

Financial Policies:

- We are available for you after hours and on Saturdays if you have an emergency; there will be a charge of $475.00 in addition to your treatment fees.
- We offer flexible no-interest or low-interest payment plans. Financing is subject to credit approval by the participating financial group. For your convenience, we accept Cash, Check, Master Card, Visa, American Express, Google Pay, and Apple Pay.
- Balances over 30 days old will accrue an interest charge of 1.5% monthly or 18% annually and a $15.00 monthly late fee if payment is not received by the due date. If it becomes necessary to refer your account to a collection agency, you will be responsible for all expenses including but not limited to court costs, reasonable attorney's/collection fees, an account service fee of $25.00, and a surcharge of 40%.
- Returned checks are subject to a $50.00 service charge.
- Broken and canceled appointments are subject to $100.00 missed appointment charge. A forty-eight (48) business hour notice is required to avoid such charges. More information available on Broken Appointment and Cancellation Policy Consent Form.
- Procedures that involve laboratory work i.e. crowns, dentures, etc. If you fail to maintain your appointment for delivery of your case, you are responsible for laboratory fees in full and 50% of all procedure fees.
- All patients under the age of eighteen MUST be accompanied by a parent or guardian. A parent or guardian MUST remain on site while treatment is rendered.
- Copies of your x-rays and records are available at your request. We require a written request forty-eight (48) hours prior. There may be a $15 processing fee for copies of your most recent x-rays.

_____ _____

Signature of Patient (Parent/Guardian) Date