## Federal Hill Smiles

Denise M. Markoff, DDS, FAGD
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410.727.3388

*Since the cause of dental disease is a combination of many factors, and is very complex, it is necessary to investigate any possible contributing influences. The success of your treatment depends on the control of all causative factors. Please answer all the questions to the best of your ability. All responses are confidential.*

Patient's Name: ______________________________ Date: ____________
Home Address: ____________________________________________
Home Phone: ( ) ____________ Work Phone: ( )____________ Cell Phone: ( ) ____________
Best Daytime #: ❑Home ❑Work ❑Cell ❑Minor ❑Single ❑Married ❑Divorced ❑Widow
E-mail Address: ____________________ Referred by: ____________________
Birth Date: ________ SSN: ____________ College Student: ❑ Yes ❑ No ***(Please present student ID)***
Employer's Name: ____________________ Occupation: ____________________
In Case of Emergency, contact: ____________________ Phone Number: ____________

**RESPONSIBLE PARTY FOR ACCOUNT** ***(If different from above)***

Name: ____________________ Relationship to Patient: ____________ Birth Date: ____________
Address: ____________________________________________
Home Phone: ( )____________ Work Phone: ( )____________ Cell Phone: ( )____________
Best Daytime #: ❑ Home ❑Work ❑Cell Employer: ____________________ SSN: ____________

**PRIMARY INSURANCE INFORMATION**

Policy Holder: ________________ SSN/ID #:________________ Birth Date: ____________
Employer: ____________________Insurance Company: ____________ Group: ________

**MEDICAL HISTORY**

1. Are you under the care of a Physician? ☐ Yes ☐ No If so, explain? ____________________
   Name: ____________________ Phone: ____________________ Last visit: ____________
2. What medications, vitamins or herbal remedies are you currently taking? ____________________
   ________________________________________________
   ________________________________________________
3. Do you smoke or use tobacco products? ❑Yes ❑ No How much? ________ How often? ________

❑ Acid Reflux
❑ Allergies (seasonal)
❑ Alcohol Abuse
❑ Anemia
❑ Arthritis
❑ Artificial Joints
❑ Artificial Heart Valve
❑ Asthma
❑ Breathing Problems
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pain
❑ Congenital Heart Defect
❑ Depression/Anxiety

❑ Diabetes
❑ Dizziness/Light Headed
❑ Eating Disorder(s)
❑ Emphysema
❑ Endocarditis
❑ Epilepsy
❑ Excessive Bleeding
❑ Fainting
❑ Frequent Headaches
❑ Glaucoma
❑ Hepatitis A, B, C
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV+/AIDS
❑ Illegal Drug Use

❑ Kidney Problems
❑ Liver Problems
❑ Low Blood Pressure
❑ Pace Maker
❑ Radiation Therapy
❑ Seizures
❑ Sickle Cell Disease
❑ Sinus Problems
❑ Sleep Apnea
❑ Stomach Problems
❑ Stroke
❑ Shortness of Breath
❑ Serious Illness(s)
❑ Thyroid Problems
❑ Tuberculosis

❑ Tumor(s)/Growth(s)
❑ Venereal Disease(s)
❑ Yellow Jaundice
❑ Heart Condition
❑ Fever Blist/Cold Sores

**Drug Allergies**

❑ Aspirin
❑ Codeine
❑ Dental Anesthetic
❑ Erythromycin
❑ Jewelry/Metals
❑ Latex
❑ Penicillin
❑ Sulfa Drugs
❑ Tetracycline

**FEMALES**: Pregnant ❑ Yes ❑ No # weeks: ________ ❑ Birth Control Pills ❑ Breast Feeding

## DENTAL HISTORY

1. Are your gums swollen and/or irritated? ❑ Yes ❑ No
2. Does your jaw ever click and/or pop on opening or closing? ❑ Yes ❑ No
3. Have you ever had any serious problems associated with previous dental treatment? ❑ Yes ❑ No

   If so, explain ______________________________________________

**Please check any of the following that apply to you:**

- ❑ Sensitivity (hot, cold, or sweets)
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Broken teeth or fillings
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath or taste

**"If I could change my smile, I would" . . . . .**

- ❑ Make them whiter
- ❑ Make them straighter
- ❑ Close the spaces in between them
- ❑ Replace black metal fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that do not match
- ❑ Have a smile makeover

***Do you have any dental disease(s), condition(s) or problems not listed above that we should know about? If so, explain*** ______________________________________________

**Do you have or have you had any of the following:**

- ❑ Implants
- ❑ Full Dentures
- ❑ Partial Dentures
- ❑ Braces
- ❑ Gum Treatments

**On a scale of 1 to 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**

**Please share the following dates:**

Your last hygiene visit: ______/______
Your last oral cancer screening: ______/______
Your last complete x-rays: ______/______
Previous dentist: ______________________________
City: ____________________ State: ______________

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

______________________________________________
______________________________________________
______________________________________________

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

______________________________________________
______________________________________________
______________________________________________

______________________________ Patient's Signature

____________ Date

______________________________ Clinician's Signature

____________ Date

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Thank you for choosing our practice for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment. Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. Therefore, we have designed a plan that will ensure we meet this goal.

◆ **ABOUT OUR FEES**

We will review your payment options with you before any treatment is begun. To accommodate you, we accept cash, checks, Visa, MasterCard, American Express and Discover. *We extend an 8% courtesy to patients without dental benefits for payment in full by cash, check or credit card at least three (3) days before a scheduled appointment.**

◆ **YOUR INSURANCE SAVINGS**

By maximizing your insurance benefits we are able to ensure that you will save money on your dental care. As a courtesy, we will accept assignment of your insurance benefits and file your primary insurance claims. *However, we do require payment in full of your co-pay and deductible at the time of service.* It is important to understand that your insurance benefits are negotiated between your employer and your insurance company. As a result some, or perhaps all, of the services provided may be non-covered services and/or not considered reasonable or customary by your insurance company under the policy your employer has selected. Please be aware that some carriers will not allow you to assign your benefits to our office. In those cases, payment is due in full at the time of the visit and your insurance company will reimburse you directly.

◆ **THIRD PARTY OPTIONS**

**FOR THOSE PATIENTS WHO PREFER TO PAY A LITTLE EACH MONTH.** We've made special arrangements with an outside agency to allow you to complete your treatment with comfortable monthly payments. Our Patient Care Coordinator will be happy to explain how the programs work and assist with completing an application.

◆ **MISSED OR CANCELLED APPOINTMENTS**

Please help us serve you and our other patients better by keeping scheduled appointments and times. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Missed and/or cancelled appointments with less than 24-hour notice will be charged at a rate of $50/hour. Please consider your schedule carefully when making appointments.

Thank you for taking the time to read our financial agreement. Our team is committed to providing the best treatment for our patients. Our Patient Care Coordinator will be happy to answer any questions you may have regarding our financial agreement.

**LET US KNOW WHICH PAYMENT OPTION YOU PREFER**: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ 3rd PARTY OPTIONS

**BILLING CHARGES**: Are applicable if the balance is not paid within 30 days of the treatment date. A BILLING CHARGE of $5.00 will be added to the account for the current monthly billing period each month until the balance is paid. In the case of default of payment, I understand that I will be responsible for any interest on the balance due, together with any collection costs and attorney's fees incurred to effect collection on this account.

I understand the financial options of Federal Hill Smiles and agree to the above arrangements.

________________________________________ ____________________

**Patient's Signature (Parent /Guardian, if minor)** **Date**

**Not available for Invisalign cases.*

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## Acknowledgement of Receipt

## Notice of Privacy Practices

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. We would, however, like your acknowledgement that you have been notified that the notice is available for your review. You may request a paper copy of the notice by asking any of our team members.

Patient Name: ______________________________

Signature: ______________________________

Date: ______________________________

An attempt was made to obtain written acknowledgement of receipt of our privacy practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining acknowledgement
- ☐ Other (please specify)

______________________________

______________________________

______________________________

______________________________

**Team Member's Name**