

Forest Hill Dental Patient Information Form

NAME: _____ AGE: _____ SEX: _____ PREFERRED NAME: _____

First MI Last

ADDRESS: _____ APT. NO. _____ HOME PHONE: (____) _____

CITY: _____ STATE: _____ ZIP: _____ BIRTHDATE: ____ / ____ / ____ CELL PHONE: (____) _____

SS#: _____ E-MAIL ADDRESS: _____ MARITAL STATUS: (Please Circle One Below)
• SINGLE • MARRIED • WIDOWED • DIVORCED

PATIENTS EMPLOYER: _____

IN CASE OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: (____) _____

ARE FAMILY MEMBERS PATIENTS OF THIS PRACTICE? • YES • NO NAME/RELATIONSHIP: _____

IF YOU ARE NEW TO OUR PRACTICE, WHOM MAY WE THANK FOR REFERRING YOU? _____

Dental Insurance Carrier (leave blank if no dental insurance): **Policy Holder if different than patient:**

NAME: _____ NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (____) _____ GROUP: _____ DOB: ____ / ____ / ____ EMPLOYER: _____

ID#: _____

FINANCIAL AGREEMENT

GENERAL

1. The financial policy of our practice is that payment is due at the time of service, unless Financial arrangements have been made with the office manager prior to treatment.
2. Cash, personal checks, MasterCard, Visa, and Discover are accepted forms of payment.

INSURANCE

1. Dental insurance coverage is a contract between the patient and insurance company.
We will coordinate claims and payments with the insurance company.
2. All necessary information must be provided to us so that we can submit claims for you.
Without this information we will require that payment be made at the time of service.
3. We ask that you carefully read and understand your policy so that you are aware of restrictions, deductibles, and any copays.
Your estimated copay and deductible must be paid at the time service is rendered.

APPOINTMENTS

1. Cancellations with less than 24-hour notice or failed appointments will result in a fee of \$50 for the first hour, plus \$25 for each additional 30 minutes. Failed appointment fees must be paid prior to rescheduling.

DELINQUENT ACCOUNTS

1. Any insurance claims not paid within 90 days of submittal to the insurance company are due from the patient.
2. Any patient whose account is in collection status will not be seen until balance is paid in full.
3. Any patient who has not paid an outstanding balance within 90 days will be sent to the collection agency unless other arrangements have been made. All collection, court cost, and reasonable attorney fees will be applied to the patient's Outstanding balance.

Signature of Guarantor _____ **Date** ____ / ____ / ____

Name: _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental or medical care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE HAD/ BEEN TREATED FOR:

HAD ALLERGIC REACTION (HIVES/SWELLING) TO:

		<u>Yes</u>	<u>No</u>			<u>Yes</u>	<u>No</u>			<u>Yes</u>	<u>No</u>
ANY HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SMOKE/SMOKELESS TOBACCO/VAPE	<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW LONG/FREQUENCY/AMOUNT? _____			ERYTHROMYCIN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	LUNG / BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	SULFA	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE DEFECT*	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA/DO YOU USE INHALER	<input type="checkbox"/>	<input type="checkbox"/>	CODEINE	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE REPLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	LATEX	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	ADRENAL/PITUITARY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETIC (i.e. LIDOCAINE)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY IN HEALING	<input type="checkbox"/>	<input type="checkbox"/>	EPINEPHRINE	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
BYPASS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO OTHER SUBSTANCES?:					
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____					
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	OSTEOPOROSIS/PAGET'S DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____					
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>						
BLEEDING/CLOTTING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS / DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>	CANCER / TUMORS OR GROWTHS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	Type:					
BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS / DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>	_____					
HEPATITIS (circle one) A B C	<input type="checkbox"/>	<input type="checkbox"/>	HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY / RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
VERTIGO	<input type="checkbox"/>	<input type="checkbox"/>	ANXIETY/ DEPRESSION/ MENTAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>						
RHEUMATIC FEVER*	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASES	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
DIZZINESS/FAINTING	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL JOINT (HIP/KNEE)*	<input type="checkbox"/>	<input type="checkbox"/>	SUBSTANCE ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER INFECTIOUS DISEASES:					

* DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS? YES NO

NAME AND REASON: _____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT NOTED ABOVE? YES NO

Explain: _____

DATE OF LAST DENTAL APPOINTMENT?: (if here, leave blank) ____ / ____ / ____

DENTAL PRACTICE NAME & TREATMENT PROVIDED: (if here, leave blank) _____

IS A PHYSICIAN CURRENTLY TREATING YOU?: YES NO WHY?: _____

PHYSICIAN'S NAME, ADDRESS AND PHONE #: _____

HAVE YOU EVER BEEN HOSPITALIZED?: YES NO WHY?/DATE: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? (Prescription/over the counter) YES NO

Please list all prescription and/or over the counter medications :

HAVE YOU EVER TAKEN BISPHOSPHONATES? (Medication for Osteoporosis) YES NO

DO YOU HAVE WELL WATER? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DENTIST OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATIONS.

_____/_____/_____
PATIENT/PARENT/GUARDIAN SIGNATURE DATE

MEDIAL HISTORY REVIEWED: _____
DOCTOR SIGNATURE

Communication Authorization Form

**Forest Hill Dental
Ryan L. Krempel, D.D.S.
2 Colgate Drive Suite 101
Forest Hill, MD 21050
410-838-6630**

Name of patient: _____

_____ **I DO** hereby authorize Forest Hill Dental to discuss my protected health information, including but not limited to:

- appointment scheduling and confirmations
- diagnosis and treatment plans
- billing and insurance matters
- medications and prescriptions
- radiographic imaging
- other related dental information

With the following individuals:

NAME	PHONE	RELATIONSHIP
_____	_____	_____
_____	_____	_____

OR

_____ **I DO NOT** authorize this dental office to discuss my health information with anyone other than myself.

If at any time, I do not want communication to be permitted between my dental care providers and any of the individuals listed OR I wish to change and/or add an individual, I (patient/parent/guardian) am responsible for notifying Forest Hill Dental of this update.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Witness (will be signed by dental provider): _____ Date: _____