PATIENT REGISTRATION

First Name _____ Last Name_____ Date of Birth _____Today's Date _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Sex _____ Social Security # _____ E-mail _____

Person who is responsible for your account _____ Phone # _____ SSN _____

Person to contact in case of emergency _____ Phone # _____

Dentist (or Referring Specialist – Orthodontist, Endodontist, Periodontist) _____

Pharmacy Name _____ Phone # _____ Zip Code _____

INSURANCE INFORMATION (Please provide us with an insurance card)

Primary Dental Plan Name _____ Insured Name _____

Insured Relation _____ Insured DOB _____ Insured Phone _____

Insured SSN _____ Address _____

Thank you for choosing Chevy Chase Implant & Oral Surgery as your health-care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Payment is due at the time of service – We will request that you make your payment on the date that the services are rendered. We accept cash, checks, credit cards, and debit cards. For our patients who are children, you will be required to send payment with whoever brings the child to the appointment.

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. The office, however, agrees to make reasonable efforts to work directly with your insurance to obtain all available reimbursement from the insurance(s) for the service rendered. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You will be responsible for paying balance in full when a claim is still unpaid after sixty (180) days.

It is our office policy that all past due accounts be settled 180 days elapsed from the date of service. We will send you three notifications during this time period. If the payment is not made on this account and no resolution can be made, the account will be sent to a collection agency. However, we make every effort and do not send the accounts to collection while any insurance claims remain pending and until all effort to collect amounts remaining by the insurance are made. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs. This will not be done until more than 180 days have elapsed until the services were rendered.

I hereby authorize Chevy Chase Implant & Oral Surgery to release information in the course of my examination and treatment to my other doctors and/or insurance carriers concerning me or my dependent's treatments and I hereby assign to the dentist all payments for his services rendered to me or my dependents. I permit messages to be left on my phone and/or mobile phone concerning my appointment. I permit email correspondences regarding my medical/dental care treatment to other dentist or physician. I understand that email is not a confidential method of communication any may be intercepted by third parties or transmitted to unintended parties. .

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have given the opportunity to ask any questions I may have regarding this Notice.

I have read the above paragraphs and understand my financial responsibilities as outlined above. By signing below, I agree to the above stated terms and conditions.

Signature (Patient or Parent/Guardian if minor) Date

MEDICAL HISTORY FORM

Patient's Name: _____ DOB: _____ Today's Date: _____

Sex: _____Height: _____ Weight: _____ Medical history update: _____ Initial: _____

Do you have or have you ever had:	Yes	No		Yes	No
Acid Reflux?	☐	☐	Hepatitis? A / B/ C	No	
Arthritis or Joint Disease?	None		High Blood Pressure?	☐	☐
Asthma?	☐	☐	Human Immunodeficiency Virus (HIV)?	☐	☐
Blood Transfusion?	☐	☐	Kidney Disease / Dialysis?	None	
Bleeding Disorder / Anemia / Bleeding Tendency?	None		Osteoporosis / Osteopenia / Osteonecrosis?	None	
Cancer / Chemotherapy / Radiation Therapy?	None		Pain or clicking of jaws when eating?	☐	☐
Chronic Cough / Bronchitis / COPD?	None		Prosthetic Joint?	☐	☐
Congenital Heart Disease?	☐	☐	Pregnant (may be) / Nursing?	None	
Contact Lenses?	☐	☐	Prosthetic Joint (Knee, Hip, Heart Valve, Pacemaker)?	Heart Pacer	
Convulsions / Epilepsy?	None		Rheumatic Fever?	☐	☐
Damaged Heart Valves / Mitral Valve Prolapse?	None		Sinus Problem?	☐	☐
Diabetes?	☐	☐	Sleep Apnea?	☐	☐
Emphysema	☐	☐	Smoke / Tobacco Chewing?	No	
Eye Disease / Glaucoma?	None		Stroke?	☐	☐
Hay Fever?	☐	☐	Thyroid Disease?	☐	☐
Heart Murmur / Irregular Heart Beat?	None		Tuberculosis?	☐	☐
Heart Surgery / Heart Valve Replacement / Heart Attack?	None				

MEDICATIONS: Are you using any of the following? List ALL the medications you are currently taking.

	Yes	No		Yes	No		Yes	No
Anticoagulants (blood thinners)?	☐	☐	Birth Control Pills?	☐	☐	Insulin?	☐	☐

Bisphosphonates, Antiangeogenic and/or Antiresorptive Medications for osteoporosis, multiple myeloma or other cancers?

Other: _____

ALLERGIES: Are you allergic to or have you had an adverse reaction to? List any drug allergies not listed above.

	Yes	No		Yes	No		Yes	No
Antibiotics?	☐	☐	Eggs / Yolk?	☐	☐	Penicillin / Amoxicillin?	☐	☐
Aspirin?	☐	☐	Local Anesthetics?	☐	☐	Sulfa Drugs / Sulfites?	☐	☐
Codeine / Narcotics?	☐	☐	Latex?	☐	☐	Valium?	☐	☐

Other: _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____ _____

Signature of Doctor **Signature of Patient/Parent/Guardian** **Date**