PATIENT REGISTRATION

First Name _____ Last Name _____ Date of Birth _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Sex _____ Social Security # _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone # _____

Referring Dentist, Orthodontist, Endodontist, or Periodontist _____

Pharmacy Name _____ Phone # _____ Address (Zip Code) _____

INSURANCE INFORMATION (Please provide us with DENTAL insurance cards)

Primary **Dental** Plan _____ Primary Subscriber Name _____

Subscriber Relation _____ Subscriber DOB _____ Subscriber ID _____

Subscriber SSN _____ Claim Center 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, check, credit card, and debit card. 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 the balance in full when a claim is still unpaid after 180 days.**

Biopsy patient: This practice sends all tissue specimens to the pathologist for examination. You will receive a separate bill from the pathology laboratory. Although this bill is normally covered by your health insurance, in a few instances, your insurance may not cover. Payment of pathology bill is your responsibility.

Medicare patient: This practice is an opt-out practice with Medicare. The practice or the patient cannot submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period. This will be considered private contract.

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 account is overdue more than 180 days, **2.5% financial charge** will be charged monthly. If the payment is not made on this account and no resolution can be made, the account will be sent to a collection agency. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs (up to 50% of total balance), 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 and 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.

TURN THE PAGE

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: Circle Yes or NO, and if Yes please circle specifics					
Acid Reflux?	Yes	No	Heart Murmur / Irregular Heart Beat?	Yes	No
ADHD/Autism?	Yes	No	Heart Sx/Heart Valve Rep/Heart Attack? (Year _____)	Yes	No
Anxiety / Biopolar / Depression / Mental Illness?	Yes	No	Hearing Impairment?	Yes	No
Arthritis or Joint Disease?	Yes	No	Hepatitis A / Hepatitis B / Hepatitis C?	Yes	No
Asthma?	Yes	No	High Blood Pressure?	Yes	No
Blood Transfusion?	Yes	No	Human Immunodeficiency Virus (HIV)?	Yes	No
Bleeding Disorder / Anemia / Bleeding Tendency?	Yes	No	Kidney Disease/Dialysis? (If current, last date of dialysis ____)	Yes	No
Cancer/Chemotherapy/Radiation (If yes, Year? _____)	Yes	No	Osteoporosis/Osteopenia/Osteonecrosis? (List medication below)	Yes	No
Chronic Cough / Bronchitis / COPD?	Yes	No	Pain or clicking of jaws when eating?	Yes	No
Colitis / Crohns?	Yes	No	Pregnant (Currently) / Nursing (Currently)?	Yes	No
Congenital Heart Disease?	Yes	No	Prosthetic Joints (Knee/Hip/Heart Valve/Pacemaker)? (Year _____)	Yes	No
Contact Lenses?	Yes	No	Rheumatic Fever?	Yes	No
Convulsions / Epilepsy?	Yes	No	Sinus Problem?	Yes	No
Damaged Heart Valves / Mitral Valve Prolapse?	Yes	No	Sleep Apnea?	Yes	No
Diabetes?	Yes	No	Smoke / Tobacco Chewing (Currently / Stopped)?	Yes	No
Emphysema	Yes	No	Stroke? (If yes, Year? _____)	Yes	No
Eye Disease / Glaucoma?	Yes	No	Thyroid Disease?	Yes	No
Hay Fever?	Yes	No	Tuberculosis?	Yes	No

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

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

Bisphosphonates, Antiangeogenic and/or Antiresorptive Medications for osteoporosis, multiple myeloma or other cancers? Yes No

Other: _____

Other: _____

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

Aspirin?	Yes	No	Latex?	Yes	No	Valium?	Yes	No
Codeine / Narcotics?	Yes	No	Local Anesthetics?	Yes	No	Antibiotics? Specify Below	Yes	No
Eggs / Yolk?	Yes	No	Sulfa Drugs / Sulfites?	Yes	No			

Others? Yes No – If Yes, please list all of them.

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 Patient / Parent / Guardian **Date**