Odenton Family Dentistry

Thomas Lutz D.D.S.
8381 Piney Orchard Parkway. • Odenton, MD 21113
Phone: (410) 674-3400 • Fax: (410) 674-3441 • www.odentonfamilydentistry.com

WELCOME TO OUR OFFICE		DATE:
NAME (FIRST, LAST)	AGE	DATE OF BIRTH
STREET ADDRESS	CITY, STATE, ZIP CODE	
HOME PHONE NUMBER	WORK PHONE NUMBER	MOBILE PHONE NUMBER
WHOM MAY WE THANK FOR REFERRING YOU?	EMAL ADORESS	
SOCIAL SECURITY NUMBER	MARITAL STATUS	GENDER MALE FEMALE
PHYSICIAN NAME:	PHYSICIAN PHONE NUMBER	
HAVE YOU BEEN HOSPITAUZED IN THE LAST 5 YEARS? YES NO	IF YES, WHAT WAS THE ILLNESS OR PROBLEM?	

ARE YOU TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICINE(S)? YES NO

(IF YES, PLEASE LIST ALL, INCLUDING VITAMINS, NATURAL OR HERBAL PREPARATIONS, AND/OR DIETARY SUPPLEMENTS)

LIST MEDICATION NAME AND DOSAGE

ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES

(IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE AND TYPE OF REACTION):

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE CHECK IF **YOU** HAVE BEEN DIAGNOSED OR ARE CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING

__1. HIGH BLOOD PRESSURE
__2. CARDIOVASCULAR DISEASE
__3. HEART ATTACK
__ 4.CHEST PAIN / ANGINA
__5. PALPITATIONS
__6. ARTIFICIAL (PROSTHETIC) HEART VALVE
__7. PREVIOUS INFECTIVE ENDOCARDITIS
__8.DAMAGED VALVES IN TRANSPLANTED HEART
__9.ORGAN TRANSPLANT
__10. CONGENITAL HEART
__11.CONGESTIVE HEART DISEASE
__12.PACEMAKER
__13. DIABETES
__14. CANCER / CHEMO/ RADIATION
__15. BLEEDING PROBLEMS
__16. TAKING BLOOD THINNERS
__17. ANEMIA
__18. ARTHRITIS
__19. AUTOIMMUNE DISEASE
__ 20. RHEUMATOID ARTHRITIS
__21. SYSTEMIC LUPUS ERYTHEMATOSUS
__22. EMPHYSEMA
__23. SINUS TROUBLE
__24. TUBERCULOSIS
__25. EATING DISORDER
__26. GASTROINTESTINAL
__27. REFLUX HEARTBURN
__ 28. ULCERS
__29. THYROID PROBLEMS
__30. STROKE
__31. GLAUCOMA
__32. HEPATITS OR JAUNDICE
__33. UVER DISEASE
__34. EPILEPSY
__35. FAINTING SPELLS OR SEIZURES
__36. HEAD OR NECK RADIATION
__37. HEADACHE I MIGRAINES
__38. KIDNEY PROBLEMS
__39. OSTEOPOROSIS; TAKING ORAL BISPHOSPHONATES, IE, FOSAMAX
__40. RECURRENT INFECTIONS
__41. HIV OR AIDS INFECTION
__42. SEXUALLY TRANSMITTED DISEASE
__ 43. ALCOHOL ABUSE
__44.DRUG ABUSE
__45. TOBACCO USE
IF YES, SPECIFY: _____
__46. WEAR CONTACT LENSES
__47. ASTHMA
__48. SLEEP APNEA
__49. SNORING
__50. DAYTIME SLEEPINESS

WOMEN ONLY

__51. PREGNANT
__52.NURSING
__53. TAKING HORMONE REPLACEMENT
__54.TAKING BIRTH CONTROL MEDICATION
__55. FERTILITY TREATMENTS

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? YES NO

Joint Replacement. Have you had an orthopedic total joint replacement? YES NO Location/Type:
Date of Surgery: If yes, was premedication recommended?

Were you treated or scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hyperkalemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?
YES NO If yes, date treatment begin? :

Have you ever been the victim of abuse or neglect? YES NO If yes, are you currently a victim?: YES NO

INSURANCE INFORMATION

As a courtesy to our patients, we file your dental insurance. Dental insurance is not like medical coverage and rarely covers the same percentages. Your dental insurance is a contract between your employer and your insurance company for your benefit. The professional treatment and dental services offered by Dobbin Dental Suite are for your best oral health and will not be dictated by insurance coverage.

Odenton Family Dentistry requires that you provide your social security number. If you refuse to provide your social security number, we will be unable to provide services. We are bound by privacy and security laws covered under the Health Insurance Portability and Accountability Act (HIPAA), which protects identifiable information and sets national standards for the security of electronic protected health information. A copy of our HIPAA policy is available upon request.

You are responsible for the deductible and percentage not covered by insurance for the work performed by Odenton Family Dentistry on the day of service. For insurances that do not pay our office directly, you will be responsible for payment in full and we will submit insurance claims with payments to be sent to you. We have many payment options, including cash, credit, or check, and we are available at any time to discuss the best option for you.

We file many of our claims electronically, therefore a signature on file is required by all dental insurance companies. We must have a completed insurance form along with social security number and date of birth to file your insurance.

We will always do our best to help you maximize your dental benefits, however, ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning treatment.

INSURANCE INFORMATION NEEDED TO FILE YOUR CLAIM

Policy Holder's Name: _____Relationship to Patient_____
Group Number:_____ Subscriber ID:_____ Policy Holder's SS#:_____
Policy Holder's Date of Birth: _____
Policy Holder's Employer Name:_____
Employer Address: _____
Occupation:_____
Employer Phone #: _____
Insurance Company Name: _____ Phone #:_____
** If you have a secondary insurance, please check ___ here and fill out another insurance information form.

RELEASE OF INFORMATION

I authorize release of any dental information necessary to process insurance claims.

_____ _____
Signature: Date:

FNANCIAL POLICY

If it becomes necessary to send my account for collection, I understand and agree that I will pay reasonable and customary attorney's fees, all cost of suit and fees owed to the Corporation of Dobbin Dental Suite.

Signature: Date:
_____ _____

I understand that should I elect not to sign this agreement, I agree to pay at the time of service regardless of insurance coverage.

Signature: Date:
_____ _____