Odenton Family Dentistry

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Welcome to our office!		**Today's Date:**	
NAME (First, Last)		**Birthdate:**	Age:
Street Address:	**City, State, Zip Code:**		
Home Phone Number:	**Mobile Phone Number:**		
Whom may we thank for referring you?	**Email Address:**		
Social Security Number:	**Marital Status:**	**Gender:** **Male** **Female** **Non-binary**	
Emergency Contact Name (First, Last):	**Emergency Contact Phone Number:**		
Physician Name:	**Physician Phone Number:**		
Have you been hospitalized in the last 2 years? Yes No	**If yes, what for?**		

Are you taking any prescription or over the counter medicine(s)? Yes No
(If yes, please list all, including vitamins, herbs and/or supplements, and/or dietary supplements)

List medication **name** and **dosage** below:

Are you taking any **blood thinners**?
□ Yes □ No

Are you taking any medications to treat **osteoporosis**?
□ Yes □ No

Do you have any allergies to medications or other substances? Yes No
(If yes, please list the name of the medication/substance, and type of reaction):

Continuation of space for allergies to medication, if needed:

MEDICAL HISTORY

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

Heart (Cardiac) Health

☐ Yes ☐ No | Arteriosclerosis

☐ Yes ☐ No | Artificial (Prosthetic) Heart Valve

☐ Yes ☐ No | Congenital Heart Disease (CHD)

☐ Yes ☐ No | Congestive Heart Failure

☐ Yes ☐ No | Coronary Artery Disease

☐ Yes ☐ No | Damaged Heart Valves

☐ Yes ☐ No | Heart Attack

☐ Yes ☐ No | Heart Murmur/Rhythm Disorder

☐ Yes ☐ No | Pacemaker/Implanted Defibrillator

☐ Yes ☐ No | Previous Infective Endocarditis

☐ Yes ☐ No | Repaired (Completely) In Last 6 Months

☐ Yes ☐ No | Repaired Congenital Heart Disease (CHD) With Residual Defects

☐ Yes ☐ No | Rheumatic Heart Disease

☐ Yes ☐ No | Unrepaired, Cyanotic Congenital Heart Disease (CHD)

☐ Yes ☐ No | Stroke

Breathing (Respiratory) Health

☐ Yes ☐ No | Chronic Bronchitis

☐ Yes ☐ No | Emphysema

☐ Yes ☐ No | Asthma

☐ Yes ☐ No | COPD

☐ Yes ☐ No | Sinus Trouble

Autoimmune

☐ Yes ☐ No | Aids or HIV Infection

If Yes, Please Specify: _____

☐ Yes ☐ No | Lupus

Brain (Neurological)/Mental Health

☐ Yes ☐ No | Anxiety

☐ Yes ☐ No | Depression

☐ Yes ☐ No | Epilepsy

☐ Yes ☐ No | Mental Health Disorder(S)

If Yes, Please Specify: _____

☐ Yes ☐ No | Neurological Disorders

If Yes, Please Specify: _____

☐ Yes ☐ No | Post-Traumatic Stress Disorder

☐ Yes ☐ No | Traumatic Brain Injury or Concussion

If Yes, Please Specify: _____

Digestive Health Gastrointestinal Disease

☐ Yes ☐ No | G.E. Reflux/Persistent Heartburn (GERD)

☐ Yes ☐ No | Stomach Ulcers

☐ Yes ☐ No | Gastrointestinal Disease

Eye (Vision) Health

☐ Yes ☐ No | Glaucoma

Sleep

☐ Yes ☐ No | Sleep Apnea

☐ Yes ☐ No | Snoring

Women's Health

☐ Yes ☐ No | PCOS/PMOS

Blood (Circulatory) Health Anemia

☐ Yes ☐ No | Blood Transfusion:

If Yes, Date of Transfusion:

_____

☐ Yes ☐ No | Hemophilia

☐ Yes ☐ No | High Blood Pressure

☐ Yes ☐ No | Low Blood Pressure

Bone Health

☐ Yes ☐ No | Osteoporosis

If yes, please list medication(s) taken:

_____

Other

☐ Yes ☐ No | Arthritis

☐ Yes ☐ No | Chronic Pain

☐ Yes ☐ No | Diabetes (Type I Or II)

If Yes, Please Specify: _____

☐ Yes ☐ No | Eating Disorder

If Yes, Please Specify: _____

☐ Yes ☐ No | Frequent Infections

If Yes, Please Specify: _____

☐ Yes ☐ No | Hepatitis, Jaundice or Liver Disease

If Yes, Please Specify: _____

☐ Yes ☐ No | Immune Deficiency

☐ Yes ☐ No | Kidney Problems

☐ Yes ☐ No | Malnutrition

☐ Yes ☐ No | Rheumatoid Arthritis

☐ Yes ☐ No | Sexually Transmitted Infection (STI)

☐ Yes ☐ No | Tuberculosis **Cancer** ☐ Yes ☐ No | Cancer Type: _____ Date Of Diagnosis: _____ Chemotherapy: _____ Radiation Treatment: ☐ Yes ☐ No	☐ Yes ☐ No | Pregnant If Yes, Please Specify the Number of Weeks: _____ ☐ Yes ☐ No | Nursing ☐ Yes ☐ No | Fertility Treatment ☐ Yes ☐ No | Taking Birth Control	☐ Yes ☐ No | Alcohol And/or Drug Abuse ☐ Yes ☐ No | Nicotine Use If Yes, Please Specify: _____ **Please list any additional medical information below:**

Have you ever been the victim of abuse or neglect? ☐ Yes ☐ No
If yes, are you currently a victim? ☐ Yes ☐ No

Today's Date: _____

Patient Name (Print): _____

Patient Signature: _____

Insurance Information

Please fill out your dental insurance information below:

Primary Insurance Information

Policy Holder's Name: _____

Policy Holder's Date of Birth:

_____

Policy Holder's SS#: _____

Relationship to Patient: _____

Insurance Company Name:

_____

Subscriber ID #: _____

Group #: _____

Insurance Company Phone #:

_____

Secondary Insurance Information (If applicable)

Policy Holder's Name: _____

Policy Holder's Date of Birth:

_____

Policy Holder's SS#: _____

Relationship to Patient: _____

Insurance Company Name:

_____

Subscriber ID #: _____

Group #: _____

Insurance Company Phone #:

_____

Odenton Family Dentistry

Notice of Privacy Practices and Information Sharing Consent

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Odenton Family Dentistry may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Odenton Family Dentistry has always taken great care to protect the integrity and confidentiality of your healthcare information; we are required by HIPAA to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practice.

I hereby acknowledge that I can obtain a copy of Odenton Family Dentistry's, NOTICE OF PRIVACY PRACTICES, upon request.

_____

Initials of patient or patient/guardian

Permission to Share Medical & Dental Information

My medical/dental information may be disclosed to relevant entities, only when pertaining to my treatment and care at Odenton Family Dentistry.

_____

Print name of patient or parent/guardian

_____

Signature of patient or patient/guardian

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by Odenton Family Dentistry to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes the release of my information to the insurer or agency given to Odenton Family Dentistry for participating health insurance plans.

_____

Signature of patient or parent/guardian Date

Broken Appointment Policy

We reserve the appropriate amount of time in preparation for each patient's appointment. To ensure that our providers' time is used as effectively as possible, we have found it necessary to adopt the following policy regarding broken appointments

Unforeseeable events occur in our everyday lives, and we understand that you may need to cancel or reschedule an appointment. **We request that you make any changes to your appointment at least 48 hours before your scheduled appointment date.**

Exceptions to this rule are situations where a true emergency has occurred and will be considered on a case-by-case basis.

An appointment is considered "broken" if the patient:

- does not show up for their scheduled appointment.
- cancels their scheduled appointment with **less than 48 hours** of notice.

Broken appointment fees:

Please be advised that there are fees associated with **each** broken appointment. A "late cancellation" will result in a **$40** fee, and a "no-show" will result in a **$45** fee.

These fees are not covered by insurance and will be billed directly to the patient.

Acknowledgment:

I have read and acknowledged that I understand Odenton Family Dentistry's policy regarding broken appointments. I agree to abide by the terms stated above.

Print Name: _____ Date: _____

Signature: _____