pearl smiles
DENTAL

6020 Meadowridge Center Dr. Ste. A, Elkridge, MD 21705

Patient Information

Patient Name: _____ (_____) Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Email: _____

Address: _____
Street City State Zip Code

Billing and Insurance

Primary Dental Insurance_____ Member ID _____
Plan/Group Number: _____ Ins. Company Phone #_____
Insured Name:_____ Insured Date of Birth:_____
Relationship to Insured_____ Insured's Address _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies _____,
- ☐ Anemia
- ☐ Atrial Fibrillation
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer_____
- ☐ Diabetes
- ☐ Dizziness
- ☐ DVT/PE_____
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid
- ☐ Tumors
- ☐ Ulcers
- ☐ Atrial Fibrillation
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Allergies to medication:
*
*
*

Are you currently taking:
Aspring ☐ Heparin ☐
Xarelto ☐ Eliquis ☐
Pradaxa ☐ Savaysa ☐
Lovenox ☐ Warfarin ☐

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Please list the medications and dosage that you are currently taking: _____

_____

Emergency Contact: _____ Phone: _____ Relationship: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient
☐ Internet ☐ Website ☐ Brochure ☐ Other _____

Name of person or office referring you to our practice: _____

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Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care.
We are always available to answer your questions or assist you.

PRIOR TO TREATMENT WE WILL DISCUSS ALL NEEDED TREATMENT UNTIL YOU ABSOLUTELY UNDERSTAND WHAT THE BEST TREATMENT NECESSARY IS FOR YOU. AT THE COMPLETION OF THE CONSULTATION WE WILL FINALIZE AND SETTLE ALL FINANCIAL ARRANGEMNTS FOR TREATMENT USING THE FOLLOWING OPTIONS:

Optional Payment Terms:

1. **Full Pay Cash Discount**: We offer a 5% accounting courtesy for all treatment over $500 that is paid in full in cash at the time of service.

2. **Credit Card Payment Option**: We accept all major credit cards including: Visa, MasterCard, Amex, Discover

3. **Term Loan**: By arrangement with Care Credit.

* ***Please note that payment is expected at the time of service***.

FOR INSURANCE PATIENTS:

If you have dental benefits, we are happy to help you receive your maximum allowable benefits. We will gladly discuss your proposed treatment and answer any questions you have regarding your benefits.

We must emphasize that regardless of what we calculate as your dental benefit, *YOU* are responsible for the *TOTAL TREATMENT FEE*. As a courtesy, we will submit your insurance claims. Your treatment estimate is based on limited information obtained from your insurance company about your benefits. We allow 45 days for your insurance company to make payment. AFTER THIS TIME THE TOTAL FEE BECOMES YOUR RESPONSIBILITY.

REFUND POLICY: Refund will be made in 4 to 6 weeks or after insurance payments and payment plans have been applied to patient's account. Any work completed will be deducted from the total amount.

Broken appointments: We are reserving a dedicated time slot just for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require a 48 hours' notice to avoid a $25.00 cancellation fee (emergencies are an exception). To reserve an appointment that is more than 30 minutes long we require 50% deposit of the treatment cost. If a patient is more than 20 minutes late or cancel an appointment (over 30 minutes long appointment) without a 48 hours prior notice, a $100 cancellation fee will be charged.

_____ _____

Date Print Name Signature

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

_____
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

_____

_____