Dr. William Yant, Dr. Timothy Longest & Dr. Elaine Allen
DENTAL HEALTH GROUP
ENHANCING SMILES • ENHANCING HEALTH

New Patient Forms Checklist

Please complete the following forms and either bring them with you to your first appointment OR drop them off at the office prior to your scheduled appointment:

( ) Patient Registration
( ) Medical History
( ) Dental History
( ) Medication Summary
( ) Office Financial Policy – Insurance Release Policy
( ) HIPAA- Patient Confidentiality

*** IMPORTANT*** As part of the new patient exam, we will take new x-rays. If you have had current x-rays taken and would like us to use them, please have them forwarded to our office prior to your scheduled first visit.

To help you obtain your records prior to your first appointment, please fill out the following and give to your current provider or return to our office and we will process the request:

( ) REQUEST FOR THE RELEASE OF PATIENT RECORDS

- Please review your dental insurance policy for x-ray coverage. Some insurances will cover one set of x-rays per year.

15703 Garrett Highway, Oakland, MD 21550 • ph. 301.334.2225 • fx. 301.334.2331
101 Drane Drive, Accident, MD 21520 • ph. 301.746.8480 • fx. 301.746.7110
www.DentistryatDeepCreek.com

Patient Registration

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

Address _____ Phone (Res): ____/____/____

_____ Work: ____/____/____ Ext: ____
City State Zip Code

Appointment confirmations are sent via Text and Email:

Cell# ____/____/____ Email _____

If Child: Parent's Name _____

Social Security No. _____ Spouse Name _____

Driver's License # _____ State _____ Spouse Social Security No. _____

Patient/Parent Employed By _____ Spouse Employed by _____

Who is Responsible for this account? _____

How did you hear about our office? ☐ Referral/Name _____
☐ Website ☐ Newspaper ☐ Radio ☐ Phonebook

Other family members in this Practice _____

Person to contact in case of emergency _____ Phone # ____/____/____

DENTAL INSURANCE INFORMATION

Primary:
Employee Name _____ DOB _____

Employer Name _____ Yrs ____

Insurance Co. Name _____

Address _____

City _____ State _____ Zip _____

Telephone # _____ S.S.# _____
ID# _____ Gp# _____

Secondary:
Employee Name _____ DOB _____

Employer Name _____ Yrs _____

Insurance Co. Name _____

Address _____

City _____ State _____ Zip _____

Telephone # _____ S.S.# _____
ID# _____ Gp# _____

RELEASE: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize the dentist to take diagnostic and treatment photographs and give permission for the dentist to use these for treatment and educational purposes only.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

Patients/Guardian's Signature _____ Date _____

Medical History

Name: _____ Date of Birth: ___/___/___ Date ___/___/___

What is your general state of health? Excellent_____ Good_____ Fair_____ Poor_____
Name/address/phone number of physician:

_____

_____

_____

Have you been under a physician's care during the last two years? ..... Yes ( ) No ( )
What is the date of your last physical? ..... ____/____/____
Have you been treated in a hospital in the past three years? ..... Yes ( )No ( )
Have you had major surgery? Yes ( ) No ( ) Why? _____
Have you ever taken Fosamax, Boniva, or any other medications containing Bisphosphonates? Yes ( ) No ( )
Do you use tobacco? Yes ( ) No ( ) How much? _____
If female: Are you pregnant? _____ Nursing: _____ On birth control: _____

Do you have any of the following?

Yes/No	Yes/No	Yes/No
( ) ( ) AIDS/ HIV	( ) ( ) Eating Disorder	( ) ( ) Pneumonia
( ) ( ) Alzheimer's disease	( ) ( ) Emphysema/ Bronchitis	( ) ( ) Radiation Therapy
( ) ( ) Anaphylaxis	( ) ( ) Epilepsy/ Seizures	( ) ( ) Rheumatic Fever
( ) ( ) Arthritis/Gout	( ) ( ) Fainting/ Dizziness	( ) ( ) Sinus Problems
( ) ( ) Artificial Heart Valves	( ) ( ) Fibromyalgia	( ) ( ) Sexually Transmitted Disease
( ) ( ) Artificial Joints/ Prosthesis	( ) ( ) Heart Murmur	( ) ( ) Stomach/Intestinal Disease
( ) ( ) Asthma	( ) ( ) Heart Problem	( ) ( ) Stroke
( ) ( ) Blood Disorder/Anemia	( ) ( ) Heart Surgery	( ) ( ) Thyroid Disease
( ) ( ) Blood Transfusion, Year:_____	( ) ( ) Hepatitis A, B, C	( ) ( ) Tuberculosis/ PPD+
( ) ( ) Breathing Problems	( ) ( ) Hypoglycemia	( ) ( ) Venereal Disease
( ) ( ) Bruise/ Bleed Easy	( ) ( ) Irregular Heart Beat	( ) ( ) Weight Loss Meds
( ) ( ) Cancer	( ) ( ) Kidney Problems	Fen-phen, Redux, etc
( ) ( ) Chemotherapy	( ) ( ) Liver Disease	
( ) ( ) Chest Pain/ Angina	( ) ( ) Mitral Valve Prolapse	
( ) ( ) Cold Sores/ Fever Blisters	( ) ( ) Nervous/Anxious	
( ) ( ) Congenital Heart Disorder	( ) ( ) Osteoporosis	
( ) ( ) Cortisone Medicine	( ) ( ) Organ Transplant	
( ) ( ) Diabetes	( ) ( ) Pacemaker	
( ) ( ) Dry Mouth	( ) ( ) Persistent Cough	

Do you have any condition, disease, or problem not previously listed? _____
If so explain:_____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my health status.

Signature: _____ Date:_____

Dental History

Name: _____ Date of Birth: ___/___/___ Date ___/___/___

Previous Dentist Name: _____

Address: _____ Tel. ____-_____-_____

_____

1. How long since your last dental visit? _____
2. What was done at that visit? _____
3. Are you having any dental problems that require immediate attention? _____

_____

4. Have you made regular dental visits? ..... Yes No
5. Were x-rays taken? ..... Yes No
6. Have you lost any teeth or have any teeth been removed? ..... Yes No
7. Have they been replaced by: Dental Implants _____ Fixed Bridges _____
   Removable Partials _____ Dentures _____
8. Are you comfortable with your replacements? ..... Yes No
9. Are you unhappy with your replacements? ..... Yes No
   If so why? _____
10. Do you have any loose or broken fillings? ..... Yes No
11. Do you usually have cavities? ..... Yes No
12. Are any of your teeth sensitive to: ( ) Hot ( ) Cold ( ) Sweets ( ) Chewing
13. Does food get caught between your teeth (food traps)? ..... Yes No
14. Are any teeth chipped or worn? ..... Yes No
15. Do you clench or grind your teeth? ..... Yes No
16. Does your jaw Click or Pop? ..... Yes No
17. Have you experienced any pain / soreness in face muscles or jaw joints? Yes No
18. Do you have frequent headaches, neck aches, or shoulder aches? ..... Yes No
19. Have you ever been told you have TMJ? ..... Yes No
20. Does your bite feel uncomfortable? ..... Yes No
21. Have you had any orthodontic work? ..... Yes No
22. Have you ever been told you have Periodontal Disease? ..... Yes No
23. Have you ever had periodontal (gum) treatment? ..... Yes No
24. Do your gums bleed while cleaning? ..... Yes No
25. How often do you daily: Brush? _____ Floss _____ Mouth Rinse _____
26. How do you feel about the appearance of your smile? _____

_____

27. I am interested in learning more about esthetic dentistry? Yes No
28. I am concerned about the whiteness/ or lack of whiteness of my teeth Yes No
29. What improvements would you like to make in your mouth? _____

_____

30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
31. I have dental fear/anxiety and would like to discuss Sedation Dentistry Yes No
32. Please add anything else you feel is important: _____

_____

33. Please indicate your goal for your dental health:
    1. I will keep all my teeth for the rest of my life
    2. I will keep most of my teeth for the rest of my life
    3. I will have tooth loss and eventually dentures

Medication Summary

Name: _____ Date of Birth: ___/___/___ Date ___/___/___

DRUG ALLERGIES:

Yes/No	Yes/No	Yes/No
( ) ( ) Aspirin	( ) ( ) Tetracycline	( ) ( ) Metal sensitivity
( ) ( ) Codeine/hydrocodone	( ) ( ) Latex	( ) ( ) Other
( ) ( ) Dental Anesthetics	( ) ( ) Penicillin	

Any allergies or adverse reactions to medications not listed?:

_____

_____

_____

_____

Please list all medications you are taking, including over the counter drugs and herbs:

	Medication:	Dosage:	Reason:
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____

Signature: _____ Date: _____

Office Financial Policy
Insurance Release Policy

We are committed to providing our patients with quality professional dental care. Just as you should expect such a high level of care, we feel that patients appreciate knowing what we expect of them concerning financial matters and issues regarding insurance. PLEASE read the following, which summarizes our financial policies.

1. **Payment is due when services are rendered**. For your convenience, we accept cash, check, and Visa/Mastercard/Discover. Senior Citizen Discounts and prepayment discounts on certain procedures are available.

2. For those patients with dental insurance, **the deductible and an estimate of the co-pay are due as services are rendered.** As a courtesy to our patients, we will submit insurance claim forms.

*Please note that we can make no guarantee of any estimated coverage. We will submit a predetermination of insurance coverage for selected procedures. Insured patients should read their policies carefully to become familiar with it's benefits and limitations. It is important that you understand that in most cases, insurance is designed to reduce your costs, not to eliminate it completely. You are ultimately responsible for the full amount of your bill regardless of your insurance coverage. Any insurance payment not received after 60 days of filing becomes the responsibility of the patient.

3. For patients requiring extensive treatment, a payment plan/prepayment plan may be arranged by the Office Manager prior to treatment.
4. A $25.00 fee will be charged to accounts for broken appointments and appointments canceled with less than a 24 hour notice.
5. A $30.00 service charge will be assessed for all returned checks.
6. All unpaid balances over 30 days will be assessed a monthly finance charge of 1.5% per month (18%/year).
7. A $5.00 re-billing charge will be added to each billing statement on balances over 45 days.
8. A 33% fee will be added to any delinquent accounts that are referred to a collection agency.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I authorize the release of any information concerning my (my child's) health care, advice & treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I HAVE READ AND AGREE TO THE ABOVE POLICIES AND RELEASES. PLEASE SIGN BELOW.

Patient's or Guardian's Signature: _____

Date: _____

You may request a copy of this agreement. Please ask receptionist.

HIPAA – PATIENT CONFIDENTIALITY
William R. Yant, DDS, PA
Dental Health Group/Dental Health Group North

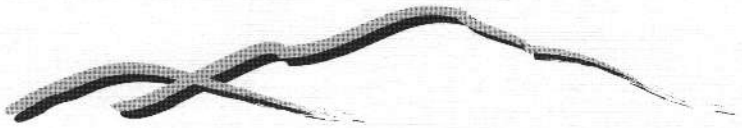
The privacy of your health and medical information is important to us. We are in compliance with privacy practices as mandated by the Federal and State laws regarding HIPAA, Health Insurance Portability and Accountability Act. We may use and disclose health information about you for treatment, payment, and healthcare operations. Our detailed **Notice of Privacy Practices** may be found on our website and at our office.

I have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date



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DENTAL HEALTH GROUP

REQUEST FOR THE RELEASE OF PATIENT RECORDS

I _____ request the release of my dental records maintained in this office. I request that they be sent to the doctor and address listed below:
Check One:

☐ Dental Health Group
15703 Garrett Highway
Oakland, MD 21550
301-334-2225 (Office No.)
301-334-2331 (Fax No.)
Email: dhg2@verizon.net

☐ Dental Health Group North
101 Drane Drive
Accident, MD 21520
301-746-8480 (Office No.)
301-746-7110 (Fax No.)
Email: dhgn1@verizon.net

Signature of Patient: _____ Date: _____

Previous Dentist: _____

Address: _____

_____

Phone #: _____