welcome

Patient's Name _____Date of Birth _____☐ Male ☐ Female

Last First Initial

How do you wish to be addressed _____

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Minor

Residence – Street _____

City _____State _____ Zip _____

Telephone: Res. _____ Bus. _____

Fax_____ Cell Phone # _____

e-Mail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is responsible for this account _____

Drivers License No. _____

Method of Payment ☐ Insurance ☐ Cash ☐ Credit Card

Purpose of visit _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to Notify in case of emergency not living with you

_____

Primary Dental Insurance

Employee Name _____ Date of Birth _____
Relationship to Patient _____
Employer Name _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or Policy # _____
Social Security No. _____
Union Local or Group _____

Secondary Dental Insurance

Employee Name _____ Date of Birth _____
Relationship to Patient _____
Employer Name _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or Policy # _____
Social Security No. _____
Union Local or Group _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of the records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer officially responsible for payment 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, by my dental payer.
I attest to the accuracy of the information on this page.

Patient/Guardian's Signature _____

Date _____

welcome

Patient's Name _____Date of Birth _____

Physicians Name_____ Phone Number _____
Address _____
When was your last complete physical exam? _____

	Yes	No
Are you under a physician's care? Since When? Why?		
Are you taking any medications or substances? If yes, please list medications in the comments section or on the back of this form.		
Do you routinely take health related substances? (Vitamins, herbal supplements, natural products)		
Are you allergic to any medications or substances? If yes, please list.		
Do you have any other allergies or hives?		
Do you have any problems with penicillin, antibiotics, anesthetics or other medications?		
Are you sensitive to any metals or latex?		
Are you pregnant or suspect you may be?		
Do you use any birth control medications?		
Have you ever been treated for or been told you might have heart disease?		
Do you have a pacemaker, an artificial heart valve implant or been diagnosed with mitral valve prolapse?		
Have you ever had rheumatic fever?		
Are you aware of any heart murmurs?		
Do you have high or low blood pressure? (please circle)		
Have you ever had a serious illness or major surgery? If so, explain:		
Have you ever had radiation treatment, chemo treatment for tumor, growth or condition?		
Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (biophosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?		
Do you have inflammatory diseases, such as arthritis or rheumatism?		
Do you have any artificial joints/prosthesis?		
Do you have any blood disorders, such as anemia, leukemia, etc?		
Have you ever bled excessively after being cut or injured?		
Do you have any stomach problems?		
Do you have any kidney problems?		
Do you have any liver problems?		
Are you diabetic?		
Do you have fainting or dizzy spells?		
Do you have asthma?		
Do you have epilepsy or seizure disorders?		
Do you or have you had venereal or any sexually transmitted disease?		
Have you tested HIV positive?		
Do you have AIDS?		
Have you had or do you test positive for hepatitis?		
Do you or have you had T.B.?		
Do you smoke, chew, use snuff or any other forms of tobacco?		
Do you regularly consume more than one or two alcoholic beverages daily?		
Do you habitually use controlled substances?		
Have you had psychiatric treatment?		
Have you taken any prescription drugs fenfluramine, fenfluarmine combined with phntermine (fen-phen), dexfenfluramine (redux), or other weight loss products?		
Do you have any disease condition, or problem not listed? If so, explain:		
Is there anything else we should know about your health not covered in this form?		
Would you like to speak to the doctor privately about any problem?		

Comments

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature_____ Date _____

Dentist's Signature _____ Date_____

welcome

Patient's Name _____Date of Birth _____

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name_____
6. Address _____Tel. _____

Comments

	Yes	No
7. Have you made regular visits? How often?		
Were dental x-rays taken?		
Have you lost any teeth or have any teeth been removed? Why?		
Have they been replaced? If yes, How have they been replaced? ☐ Fixed Bridge …… Age …… ☐ Removable Bridge …… Age …… ☐ Denture …… Age …… ☐ Implant …… Age ……		
Are you unhappy with the replacement? If yes, explain.		
Would you like to know about permanent replacements?		
Have you ever had any problems or complications with previous dental treatment? If yes, explain.		
Do you clinch or grind your teeth?		
Does your jaw click or pop?		
Have you experienced any pain or soreness in the muscles of your face or around your ear?		
Do you have frequent headaches, neck aches or shoulder aches?		
Does food get caught in your teeth?		
Are any of your teeth sensitive to the following? (Check all that apply) ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure		
How often do you brush your teeth?		
Do you floss? If yes, how often?		
Do your gums bleed or hurt? If yes, when?		
Are any of your teeth loose, tipped, shifted or chipped?		
Are you unhappy with the appearance of your teeth?		
Do you feel your breath is offensive at times?		
Have you ever had gum treatment or surgery? If yes, What? Where? When?		
Have you had orthodontic work?		
How do you feel about your teeth in general?		
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? If yes, please describe.		
Do you have any questions or concerns? If yes, please describe.		

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature_____ Date _____

Dentist's Signature _____ Date_____

Financial Agreement

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

I understand that my insurance is a contract between the insurance carrier and me, and not between the insurance carrier and this office. **I understand that quoted fees are estimates. I am fully responsible for all fees and for understanding my insurance benefits and limitations.**

This office will prepare and submit forms and reports to assist me in obtaining maximum benefits available. However, **I understand that treatment recommendations or fees are not affected by the presence or absence of insurance benefits.**

Should timely payment of this account not be made (60 days overdue), I authorize this office to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition. Any expenses incurred by such action shall be an additional liability for which I assume responsibility.

I understand that the office requires at minimum a 24 hour notice for cancelling or rescheduling an appointment. Otherwise, a $75 fee may be assessed to my account.

I am aware that nitrous oxide inhalation sedation is not a covered benefit of my insurance, and that a fee will be assessed if nitrous oxide is used during my treatment.

Print Name	Signature	Date

Medical Release Authorization

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize this office to use or disclose protected health care information to carry out treatment, payment, and health care operations.

I authorize you to call or e-mail me to discuss my dental treatment.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly. This information will also be used to obtain from third-party payers, and to conduct normal healthcare operations such as quality assessment and physician certifications.

Prior to signing this consent, I have read your *Notices of Privacy Practices* containing a more completed description of the uses and disclosures of my health information. I understand that I have the right to request in writing that you restrict how my private information is used or disclosed.

Print Name	**Signature**	**Date**

Request for Records Form

Dental Office: _____
Address: _____
_____
Phone Number: _____

I _____, herby authorize the release of dental records and current radiographs, or copies of such and request that they be transferred to:

Fedra Witting, D.D.S.
175 Admiral Cochrane Drive, Suite 103
Annapolis, Maryland 21401
410) 841-5400

Patient Name: _____
Patient DOB: _____

Patient's Signature/Parent Date

Please kindly forward all digital radiographs to staff@fedrawittingdds.com.

Office Use Only