TIME 4:20 PM

Brenda R. Paul, R.D.H., D.D.S.

DATE 9/4/2013

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

TIME 3:25 PM DATE 11/16/2017

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

RIVER CITY
DENTAL

Name _____
Last First

Date _____

Please tell us how you learned about our practice. (Select **ALL** that apply)

_____ Referral - Patient *Name:* _____

_____ Referral - Staff *Name:* _____

_____ Referral - Dentist/Dr *Name:* _____

_____ Our website

_____ Internet search (e.g. a basic search for "dentist")

_____ Insurance Company *Which insurance?* _____

_____ Facebook

_____ Agricultural Expo

_____ Previous Patient - 5 or more years

_____ Word of Mouth

Brenda R. Paul, D.D.S. RIVER CITY DENTAL **Kristen P. Schupp D.D.S.**

DENTAL HISTORY

Patient Name _____

Date _____

Previous dentist name _____ Date of last dental visit? _____

What dental aids do you use? (Sonicare, Braun, Oral B, toothpick, proxy brush ,other)

_____

Have you ever had:

Yes	No	Orthodontic treatment (braces)
Yes	No	Endodontic treatment (root canals)
Yes	No	Periodontal treatment (gums)
Yes	No	A bite plate, splint, or mouth guard
Yes	No	Your teeth ground or bite adjusted
Yes	No	Difficulty getting numb, from a previous dentist
Yes	No	A broken jaw
Yes	No	GERD (Gastro Esophageal Reflux Disease)
Yes	No	A tendency to get food caught between your teeth

Periodontal Checklist

Yes	No	Do your gums bleed when you brush or floss?
Yes	No	Are your teeth loose or separating?
Yes	No	Are gums red, swollen or tender?
Yes	No	Do you have bad breath?

TMJ Checklist

Yes	No	Jaw joint noise
Yes	No	Difficulty in opening jaw or swallowing
Yes	No	Clenching/grinding
Yes	No	Ear congestion/ringing in ears
Yes	No	Face or neck pain
Yes	No	Tired jaws, especially in the morning

Smile Evaluation

Yes	No	Do you like the way your teeth look?
Yes	No	Are you happy with the color of your teeth?
Yes	No	Would you like your teeth whiter?
Yes	No	Do you like the shape and length of your teeth?
Yes	No	Do you have missing teeth or spaces that you would like closed?
Yes	No	Would you like your teeth straighter?

If you could change anything about your teeth, what would you change?

_____

_____

_____

RIVER CITY
DENTAL

Brenda R. Paul, D.D.S.
Kristen P. Schupp, D.D.S.

415 S. Conococheague St. #100
Williamsport, MD 21795
(301)223-7440

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.
However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

RIVER CITY
DENTAL

Brenda R. Paul, D.D.S.
Kristen P. Schupp, D.D.S.

415 S. Conococheague St. #100
Williamsport, MD 21795
(301) 223-7440

Financial Policy

1.Terms:

We accept cash, checks, Visa, MasterCard, American Express and Discover for payment for services rendered.

2.Payment for Services:

Payment is due for service rendered at the time of the appointment unless prior financial arrangements have been made.

3.Insurance Coverage:

We accept assignment of benefits for those patients who have dental insurance in which we participate. Our office will accept benefits for all preventive procedures and bill the patient for any balance. Restorative, Surgical, Periodontal and Prosthetic services not requiring preauthorization, we require the co-payment at the time of the services, with the anticipated balance to be received from the assignment of benefits of the insurance plan. For all prosthetic procedures requiring preauthorization from the insurance company, we require the patient's co-payment portion of the procedure to be paid in full before insertion on the prosthetic, with the anticipated balance to be assigned from the insurance company. In all cases, any over payments from the patient's due to increase coverage from the insurance company, will be returned the balance as soon as the credit is received.

All outstanding unpaid insurance claims over 60 days will be the responsibility of the patient. Payment in full will be due and it will be the patient's responsibility to contact their employer and their insurance company for settlement.

4.Emergency Patients:

All patients, regardless of insurance, must pay for services rendered at the time of the appointment. We will process insurance forms for the insurance patients without additional charge.

5.Appointments:

All appointments are reserved for the patient so that we may provide the best dental care. If the patient is unable to keep the scheduled appointment, we require 24 hour's notice in advance. If we do not receive advance notice of the cancellation, we can charge $25.00 per half hour for the reserved treatment scheduled. If two broken appointments in succession occur we will not schedule additional appointment unless the schedule treatment is prepaid in full, in advance, so that if the patient does not show, our time has not been wasted.

6.Returned Checks:

Any returned checks which are returned for insufficient funds will be accessed a $25.00 fee.

Consent/Assignment/Guarantee

I hereby consent to treatment of the above captioned patient by this facility and further authorize the release of any dental information necessary to process claims arising from such treatment. I shall be personally liable for the fees for the services rendered. I understand that interest charges may be added to balances remaining after sixty days. If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, court costs, and attorney fees, as allowed by law.

_____ _____

Date Signature of Patient and/or Guardian (SEAL)

PAYMENT IS EXPECTED AT TIME OF SERVICE