Patient Information

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

Birth Date: _____ Gender: _____ Marital Status: _____

Social Security #: _____ Email Address: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Please review this section closely. It is essential for us to have accurate health history, allergy, and medication information in order for us to give you the highest quality of care. If more space is needed to list allergies, medications, or more detail on specific medical conditions, please use the back of this sheet and notify us that additional information has been added.

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

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

- ☐ Aids/HIV Positive
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting during proc.
- ☐ Glaucoma
- ☐ Growths/tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental/ Nervous Disorders
- ☐ Pacemaker
- ☐ Female pt: Pregnant? Due date:_____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex/Metal Reaction
- ☐ Medications: _____ _____ _____

- 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: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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 ☐ Google ☐ Website/Online ☐ Postcard/Mail ☐ 1-800-Dentist ☐ Other _____

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

Emergency Contact

Name: _____ Relationship to Patient: _____ ☐ Male ☐ Female

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

Employment Information

Employer Name: _____ Occupation: _____

Address: _____ Phone Number : _____

Dental Insurance Information

Primary Dental Insurance

Insurance Company: _____

Group #: _____ ID #: _____

If you are NOT the subscriber of this insurance plan, please fill in the following information about the subscriber:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child/Dependent ☐ Other _____

Name: _____
Last First MI

Birth Date: _____ Social Security #: _____ ☐ Male ☐ Female

Address: _____
Street City State Zip Code

Employer Name: _____

Secondary Dental Insurance (if applicable)

Insurance Company: _____

Group #: _____ ID #: _____

If you are NOT the subscriber of this insurance plan, please fill in the following information about the subscriber:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name: _____
Last First MI

Birth Date: _____ Social Security #: _____ ☐ Male ☐ Female

Address: _____
Street City State Zip Code

Employer Name: _____

Consent for Services

I hereby authorize Dr. Silverman and Associates to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I authorize the 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, and I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full of all accounts, and I agree to be responsible for payments of services not paid, in whole or in part, by my dental insurance payer. If enforcement of payment is used through the services of a collection agency, I agree to be responsible for any incidental expenses, including collection costs, court costs, and attorney fees.

I understand that Dr. Silverman reserves the right to charge for appointments cancelled or broken without 24 hours advance notice.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of Patient (Or parent/guardian)

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Dr. Silverman and Associates

23 Crossroads Drive, Suite 420
Owings Mills, MD 21117
Phone 410 356 8400 Fax 410 356 8401 www.saveteeth.com

Financial Policy

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

Payment for Services

Before treatment is performed, we will discuss treatment options and associated costs. You will always be informed of costs and financial options before commencing with treatment. For large procedures and for treatment plans that will take multiple visits, we require payment in full prior to scheduling. For all other work, payment is due at time of service. If you are working with dental insurance, we will discuss estimated insurance benefit coverage, and we will take that into account prior to payment.

We know from experience that it is best to take care of financial arrangements prior to starting treatment, so that all subsequent visits are focused 100% on your treatment and taking care of your dental needs. For your convenience we accept cash, checks, MasterCard, Visa, American Express, Discover, and debit cards. In addition, we offer patient financing for qualified lendees through CareCredit and LendingClub Patient Solutions (formerly Springstone Financing). For more information about financing options, feel free to ask.

If payment arrangements or obligations are not met, your account balance may be sent to collections. You will be responsible for any collections charges, court costs, and attorney fees for collection actions on your account. Any balance more than 90 days past due may be subject to a finance charge of 1.5% per month past 90 days over due.

Maryland state law allows us to charge a reasonable, cost-based fee for duplication of records, including for the cost of supplies and labor of copying. We reserve to right to assess this fee and require it be paid prior to transference of patient records.

Initials: _____

Dental Insurance

If you have dental insurance, we will do our best to ensure that you receive the full benefits of your coverage. We will handle the filing and processing of all claims, even though we are not in-network with any insurance provider. We will accept assignment of benefits for plans that will make claim payments directly to our office.

Insurance coverage is a contract between the patient and the insurance company, not between our office and the insurance company. Insurance companies change their rules, procedures, and payment basis often and arbitrarily, without notice to our office. We do our best to estimate what each plan will pay for different procedures, but you are responsible for any balance that insurance does not cover.

If an insurance claim has not been paid out on by your insurance carrier after 60 days from submission, we may ask that you pay for any outstanding balance from the procedure. We will continue to pursue payment from your insurance company, and if the claim is later paid on we will direct payments to you, the patient.

Initials: _____

Missed Appointments/Cancellation Policy

Our policy is to charge for missed appointments as the rate of no less than $35 per visit and no more than the cost of the appointment. Please help us serve you and our other patients by keeping scheduled appointments. Appointments that are cancelled or changed less than 24 hours from the time of the appointment become time lost for the office and for our other patients. We require you to inform our office of a cancellation or need to reschedule of any appointment at least one business day, 24 hours before the appointment (i.e. – A Monday 9am appointment needs to be cancelled by 9am the Friday before). Due to the nature of the practice of dentistry, and the advanced planning of all major treatment, such notice is mandatory.

Initials: _____

I understand the financial policy and agree to adhere to my obligations according to it.

_____ _____

Signature of Responsible Party Date