RICCARDO T. JONES, D.D.S., M.A.G.D

ARTISTRY • INTEGRITY • PASSION

Tel: 301-474-6392
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7259 HANOVER PARKWAY, SUITE A
GREENBELT, MD 20770

Advance Dental Care

PATIENT INFORMATION

Date: _____ ☐NEW PATIENT ☐UPDATE

Patient: _____
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL/LOCATION

Patient Date of Birth: _____ Patient SSN: _____

Address:

_____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

Referral? ☐Yes ☐ No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address:

_____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

WORK: _____ X
DIRECT: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

_____

_____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

_____

_____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐ FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: .....
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐OTHER – PLEASE LIST: .....
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

Missed Appointment(s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least a 48 hour notice for cancellations or for re-scheduling your appointment. If you give less than 48 hour notice your account will be charge a $75 fee for each appointment slot you are booked for. We understand that unforeseen circumstance may arise, which may result in canceling or missing your appointment. Multiple failed appointments may result in being dismissed from the practice.

Coming Late for Appointments:

We kindly give a 10 minute grace period from your appointment time. If you come any later than 10 minutes it will be considered a broken appointment and your account will be charge a $75 fee (refer to the Missed Appointment(s) and Cancellation Policy above). If we are still able to see you after the 10 minute grace period you will be charge a $35 dollar late fee.

Consent:

I have read understand and agree to the above term and conditions. Authorize my insurance company to pay me dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due before the services are rendered.

Patient/Guardian Print Name | Patient/Guardian Signature | Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian Print Name | Patient/Guardian Signature | Date

Witness | Position | Date

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental claims. Please understand that we will provide an insurance estimate to you; However, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all to ensure your estimate is as accurate as possible. Your estimate insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party of that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to our office. 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.
- We ask that you pay the deductible, co-payment and co-insurance which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express and Care Credit before we can schedule your appointment.
- Insurance payments are ordinarily received within 30 – 60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and request of your insurance company over any claim.

Minors Accompanied by Parent or Legal Guardian:

The parent or legal guardian accompanying a minor, who has consented to treatment is responsible for entire payment before we schedule appointment.

Minors Unaccompanied by Parent or Guardian:

Will be denied treatment if the parent or legal guardian is not present in the office during procedure. That will result in a broken appointment and the account will be charged $75.