PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

PATIENT'S NUMBER

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

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 THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS. PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE. IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES	☐	☐
14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS	☐	☐
15. DO YOU USE TOBACCO	☐	☐
16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
17. ARE YOU WEARING CONTACT LENSES	☐	☐
18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

PATIENT'S NUMBER

CHESAPEAKE
Dental Arts

www.ChesDentalArts.com

1509 Ritchie Hwy · Arnold, MD 21012 · (410) 757-6200

Please initial the following:

I understand all treatment plans are only an estimate and may differ from actual payments. I am responsible for the difference. _____

I understand that no financial arrangements will be made after work has been initiated. _____

I understand that 50% of my copayment is due on the start of my work and the remainder is due on the insertion. _____

When we do dentures we do not take a write off from the insurance company. Patient is responsible for any balance after insurance pays. _____

No appointments will be scheduled for any individual or family member with a balance. All work must be paid in full on the day of insertion or delivery. ____

____ Initial of person reviewing treatment plan.

Financial and Office Policies of Chesapeake Dental Arts

All Copayments will be due at the time of service. This includes fillings. For treatments with multiple appointments payments can be equally divided over the number of appointments.

5% courtesy is offered for payment in full, prior to treatment, for any procedures that total over $2500. Payment must be made in cash or check, no credit cards. Certain insurance plans may be exempt from this.

Payment Installments: If you need to break payments into smaller installments we offer no interest plans of 6 month, and longer financing up to 60 months with interest, thru an outside financial institution called Care Credit. We can help you apply. Certain procedures may be exempt from this at the office's discretion.

We accept Cash, Checks, Visa, MasterCard, and Discover

All treatment plans are an ESTIMATE. Sometimes procedures or fees may need to be changed due to clinical situations. We recommend a **preauthorization** with your insurance carrier if you want a more exact figure. There is a $5.00 charge to send preauthorizations. This takes 4-6 weeks. Please try to be familiar with your benefits; we often do not know all the little nuances of your plan. Each employer sets up different benefits for their employees so there are hundreds of different plans. But we will always try to do our best to help you navigate thru it. Read your EOB's (estimate of Benefits from your insurance company). **Please note Insurance breakdown is only an ESTIMATE. Your payment may be more if you have a deductible, if you have used up your maximum, or if there is something that is not covered by your insurance company. Any leftover balance is your responsibility. No negotiations will be made on payment arrangements after work is initiated.**

Many carriers do not offer coverage for composite (white fillings) and will change the code on the EOB's to an amalgam (metal) code. **You are responsible for the difference in cost,** although this may not be evident on your EOB. As part of our contract with many insurances we are allowed to charge the difference in fee when they change the procedure code. They are not always required to inform you of this and often the EOB is misleading. White fillings are the standard of care and account for over 85% of all fillings placed in the United States. We may not know this when we give you your estimate. We do not offer metal fillings.

There is a $50 fee for first hour and $50 for each additional hour for appointments canceled without 2 business days notice. For example if you have a 1 ½ hour appointment your fee for canceling without 2 business days notice would be $100. We reserve this appointment time especially for you and we generally cannot fill it in such short notice. The dental industry estimates missed appointments account for a loss of around $40,000 a year. This translates into higher costs for the patients who do keep their appointment times.

Accounts not paid in 90 days will incur a $25 billing charge per month until the balance is paid in full. Our computer system automatically applies this to every overdue account. No appointments will be issued to patients or families with outstanding balances.

I have read and agreed to these terms.

Patient Signature_____ Date _____

Acknowledgment of Receipt of Dr. Meredith Esposito's Notice of Privacy Practices

You may refuse to sign this form

I

_____, have been presented with a copy of Dr. Meredith Esposito's Notice of Privacy Practices.

_____

Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign

____ Communication barriers prevented us from obtaining acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (Please specify)

_____

_____

RELEASE AND PHOTO IMAGE PUBLICATION CONSENT VERIFICATION AGREEMENT

This Release and photo image publication consent verification agreement is entered into between Dr. Meredith Esposito of Chesapeake Dental Arts with its principal place of practice at 1509 Ritchie Highway Arnold, MD and _____ (patient)

Recitals

This agreement is for the purpose of identifying any express or implied agreement, including but not limited to, permission, consent, release, and/or authorization between Dr. Esposito and the patient in connection with the dental service the patient received from Dr. Esposito.

Dr. Esposito and the patient warrant and represent that the patient has given CONSENT and FULL AUTHORIZATION that any photographs and/or images of the patient, under the following conditions.

1. The photographs and/or images will be taken by Dr. Esposito or by a photographer and/or skilled operator approved by Dr. Esposito.
2. The photographs and/or images may be used for:
   A. Medical records, and in the judgment of Dr. Esposito, medical research, education or science will be benefited by their use, such photographs and/or images and information relating to the patient may be published or republished, either separately or in connection with each other, in, but not limited to professional journals, medical books, medical based internet web sites, or any other purpose which Dr. Esposito may deem proper in the interest of, but not limited to, medical education, knowledge, or research; and/or
   B. The patient further authorizes that the photographs and/or images may be used by Dr. Esposito or by any entity approved by Dr. Esposito in promotional printed computer web-site, and/or video material.
3. At no time will the patient's name, address, or any other alpha/numeric patient identifiable information be used in connection with the publication of the photographs and/or images of the patient. The patient acknowledges the possibility that his/her identity may become known as a result of the publication and use of the photographs and/or images described in paragraph 2 above.
4. The photographs and/or images may be modified and/or retouched in any way in Dr. Esposito's discretions.
5. You may choose to only agree to the use of photos or x-rays in lab cases and being sent to specialists offices.

By signing below, the patient certifies that he/she has read and understood each and every section of this agreement, and agrees to be bound by its terms.

_____ _____

PATIENT DATE

_____ _____

Dr. Meredith Esposito Date