DYNAMIC DENTAL

*13401 New Hampshire Avenue, Silver Spring, MD 20904 * 301-879-8337 * frontdesk@dynamicdds.com*

PATIENT REGISTRATION FORM

Thank you for choosing Dynamic Dental Care! We look forward to serving you.

Patient's Name _____ Please circle M F

Today's Date _____ Date of Birth _____ Soc Sec # _____

Home Address
City, State, Zip _____

Your Employer _____ Work Phone # _____

Home Phone # _____ Cell Phone # _____

Email Address _____

Person responsible for account _____ Relationship _____

Name of Spouse (Parent if minor) _____ Spouse's (Parent's) Date of Birth _____

Spouse's (parent's) Employer _____ Spouse's (Parent's) Soc Sec # _____

Spouse's (parent's) Work Phone # _____ Spouse's (parent's) Cell Phone # _____

Primary Dental Insurance Information		**Secondary Dental Insurance Infortmation**	
Insured's Name		Insured's Name	
Insured's SS#	Insured's DOB	Insured's SS#	Insured's DOB
Insured's Employer		Insured's Employer	
Insurance Company		Insurance Company	
Insurance Phone #	Group #	Insurance Phone #	Group #

Have you seen a dentist, periodontist or other dental specialist within the last year? Yes No

How did you hear about us?
Friend. Please provide name _____
Insurance company Brochure in the mail ZocDoc Other
Drove past the office/sign Website Angie's list

Emergency Contact Name _____

Phone Number _____ Relationship _____

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FINANCIAL POLICY AND CONSENT FOR TREATMENT

Thank you for choosing Dynamic Dental Care 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 you to read, agree to and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment.

An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. We will be sensitive to your financial circumstances and will do everything possible to help you achieve oral health.

Dynamic Dental Care requires payment prior to the completion of your treatment, unless prior financial arrangements have been made. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. Our office accepts cash, check, Visa, MasterCard, American Express or Discover Card. We also accept CareCredit Healthcare Credit Card, including their six and twelve months no interest payment plans. We are also happy to establish in-house payment plans. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee to cover the processing fees that are charged to our office.

Deposit Policy

Due to the extensive amount of time our doctors and team members devote to preparing and reserving uninterrupted time for you, we require a $50 deposit to reserve any appointment time longer than one hour.

Rescheduling/Change in Schedule Policy

Our practice is dedicated to quality care and exceptional service. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of **two business days** notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee of $50.00 will be charged for any missed or broken appointment, and any deposit paid will not be refunded or applied to your treatment.

Do you have dental insurance?

- ✓ We are happy to work with you and your insurance company to maximize your benefits. As part of our service to you, we will provide a detailed estimate of the expected insurance payment for your treatment; however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- ✓ We are pleased to directly bill your insurance company for payment for your treatment. In the event that your insurance company does not pay for services rendered, all charges you incur are your responsibility regardless of your insurance coverage.
- ✓ Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. If we are a participating provider in your insurance plan, we abide by the negotiated reduced insurance fees for services covered by your insurance plan.
- ✓ We ask that you sign this form and/or any other documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- ✓ We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide service to you.
- ✓ Insurance payments are ordinarily received 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will 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 requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Don't have traditional dental insurance?

- ✓ We are proud to offer our own affordable in-house insurance plans. Ask one of our team members for details.

I have read, understand and agree to the Financial Policy and hereby consent to treatment at Dynamic Dental Care.

Patient Signature (Parent if child) Patient Name (Please Print) Date

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Patient's Name _____ **Date of Birth** _____

DENTAL HISTORY

Please check if any of the following apply:	Yes	No
-Sensitivity (hot, cold, sweet, pressure) Where? UR LR UL LL	□	□
-Headaches, earaches neck pain	□	□
-Jaw joint pain	□	□
-Teeth or fillings breaking	□	□
-Grinding or clenching of teeth	□	□
-Bleeding, swollen or irritated gums	□	□
-Loose, tipped or shifting teeth	□	□
-Bad breath	□	□
-Do you have or have you had:		
-Dentures	□	□
-Partial dentures	□	□
-Braces	□	□
-Periodontal (gum) treatments	□	□

Please share the following dates:
Your last cleaning _____ / _____
Your last oral cancer screening _____ / _____
Your last complete x-rays _____ / _____
Name of Previous Dentist _____
City, State _____
Phone Number _____
Why did you leave your previous dentist?

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	□	□
Do you smoke or use chewing tobacco?	□	□
How much?_____ How long? _____		
If I could change my smile, I would:		
-Make if whiter	□	□
-Make it straighter	□	□
-Close spaces	□	□
-Replace black metal fillings with tooth colored restorations	□	□
-Repair chipped teeth	□	□
-Replace missing teeth	□	□
-Replace old crowns that don't match	□	□
-Have a smile makeover	□	□

ON A SCALE OF 1-10 WITH 10 BEING THE HIGHEST:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

MEDICAL HISTORY

Are you taking any medications, pills or drugs? If Yes, list:	□Yes □No	
Are you under a physician's care?	□Yes □No	
Have you ever been hospitalized or had a major operation?	□Yes □No	Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Sulfa Drugs □ Latex □ Other
Have you ever had a serious head or neck injury?	□Yes □No	Women: Are you: □ Pregnant/Trying to be? □ Taking oral contraceptives? □ Nursing?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	□Yes □No	
Do you use tobacco?	□Yes □No	Physician Name & Phone No:

Do you have, or have you had, any of the following?				
	□ Cancer	□ Frequent Diarrhea	□ Hypoglycemia	□ Rheumatism
	□ Chemotherapy	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever
	□ Chest Pains	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ AIDS/HIV Positive	□ Cold Sores/Fever Blisters	□ Glaucoma	□ Leukemia	□ Sickle Cell Disease
□ Alzheimer's Disease	□ Congenital Heart Disorder	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Anaphylaxis	□ Convulsions	□ Heart Attack/Failure	□ Low Blood Pressure	□ Spina Bifida
□ Anemia	□ Cortisone Medicine	□ Heart Murmur	□ Lung Disease	□ Stomach/Intestinal Disease
□ Angina	□ Diabetes	□ Heart Pacemaker	□ Mitral Valve Prolapse	□ Stroke
□ Arthritis/Gout	□ Drug Addiction	□ Heart Trouble/Disease	□ Osteoporosis	□ Swelling of Limbs
□ Artificial Heart Valve	□ Easily Winded	□ Hemophilia	□ Pain in Jaw Joints	□ Thyroid Disease
□ Artificial Joint	□ Emphysema	□ Hepatitis A	□ Parathyroid Disease	□ Tonsillitis
□ Asthma	□ Epilepsy or Seizures	□ Hepatitis B or C	□ Psychiatric Care	□ Tuberculosis
□ Blood Disease	□ Excessive Bleeding	□ Herpes	□ Radiation Treatments	□ Tumors or Growths
□ Blood Transfusion	□ Excessive Thirst	□ High Blood Pressure	□ Recent Weight Loss	□ Ulcers
□ Breathing Problem	□ Fainting Spells/Dizziness	□ High Cholesterol	□ Renal Dialysis	□ Venereal Disease
□ Bruise Easily	□ Frequent Cough	□ Hives or Rash	□ Rheumatic Fever	□ Yellow Jaundice

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child) **Date** **Dentist Signature**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

YOU ARE ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT AFTER YOU SIGN IT

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

Contact Phone Number _____

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself, covered under the Privacy Act, to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name of Person	**Relationship**	**Contact Phone Number**
Name of Person	**Relationship**	**Contact Phone Number**
Name of Person	**Relationship**	**Contact Phone Number**

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign

____Communications barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify)