Family Values Dental Care
772 National Highway
LaVale, MD 21502
Ph # : 301-729-6911
Fax # : 240-362-9921

Family Values DENTAL CARE

Patient Personal Information

Title _____ Nickname _____ Birth Date _____ Age _____
Last, First _____ Marital Status _____ Sex _____
Address _____ Home # _____ Work # _____
_____ Cell # _____
City, State, Zip _____
Email _____

Person responsible/guarantor for paying bills

Title _____ Nickname _____ Birth Date _____ Age _____
Last, First _____ Marital Status _____ Sex _____
Address _____ Home # _____ Work # _____
_____ Cell # _____
City, State, Zip _____
Email _____

Do you have Primary Dental Insurance? No	**Do you have Secondary Dental Insurance?** __ Yes __ No
Group No/Name	Group No/Name
Insurance Name	Insurance Name
Phone #	Phone #
Employer Name	Employer Name
Subscriber Last, First	Subscriber Last, First
Subscriber Address	Subscriber Address
City, State, Zip	City, State, Zip
Relationship to Patient Birth Date	Relationship to Patient Birth Date
Subscriber ID	Subscriber ID

Patient Medical Information

Check "PREMED" if you need antibiotic for dental visits
☐ Y ☐ N PREMED
☐ Y ☐ N PREGNANT

Allergy or Reaction to
☐ Y ☐ N *Penicillin
☐ Y ☐ N *Sulfa Drugs
☐ Y ☐ N *Erythromycin
☐ Y ☐ N *Keflex
☐ Y ☐ N *Local Anesthetic
☐ Y ☐ N *Codeine
☐ Y ☐ N *Metal
☐ Y ☐ N *Epinephrine
☐ Y ☐ N *Fluoride
☐ Y ☐ N *Other Allergy or Reaction

Medical Conditions
☐ Y ☐ N AIDS / HIV Infection
☐ Y ☐ N Asthma
☐ Y ☐ N Bleeding Disorder
☐ Y ☐ N Cancer
☐ Y ☐ N Cardiac Pacemaker
☐ Y ☐ N Chest Pain
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Seizures
☐ Y ☐ N Fainting Spells / Dizziness
☐ Y ☐ N Sjogren's Disease
☐ Y ☐ N Heart Attack / Stroke
☐ Y ☐ N Heart Valve Disorder
☐ Y ☐ N Hepatitis

Medical Conditions
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Hole in Heart
☐ Y ☐ N Kidney Disease
☐ Y ☐ N Liver Disease
☐ Y ☐ N Recurring Infection
☐ Y ☐ N Tuberculosis

Surgery
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Transplant

Medicines
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Blood Pressure Medicine
☐ Y ☐ N Blood Thinners
☐ Y ☐ N Bone Medicine
☐ Y ☐ N Illegal Drugs

Dental Questionnaire

Name and location of your previous dentist _____

How long ago was your last dental visit?

Have you had any problems associated with previous dental treatment? If so, explain.

How did you learn about our office? (friend, phone book, website, insurance list, sign)

What is the reason for your dental visit today?

Medical Questionnaire

Medical Conditions

Family physician (name and phone number)

Who should we contact in case of emergency? (name and phone number)

List any serious illness, operation, or hospitalization over the past 10 years.

Medications

Are you currently taking any medication? If so, please list.

Have you taken Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid or Reclast?

Has a physician or dentist told you to take antibiotics prior to your dental treatment?

Do you smoke?

Women Only

Are you pregnant? What is your due date?

Are you currently nursing?

Are you on birth control pills or fertility drugs?

Additional Comments

Any disease, condition, or problem not listed? Please list.

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Family Values Dental Care
Ryan Wratchford DDS

Financial Policy

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment unless otherwise arranged.

Payment options:
1. Cash
2. Check
3. MasterCard
4. Visa
5. Discover

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay within 60 days, we will bill you directly for the full balance and you will be responsible for collecting reimbursement from the insurance company.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records will be available for your viewing within 3 business days of your request. There may be a nominal charge for release or copies of records.

Appointment information will be relayed to you via phone, answering machine, mail, email, or text. If you wish not to receive correspondence by one of the above please notify the office.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I _____ agree to these financial terms. I allow Family Values Dental Care to bill my insurance company and receive benefits on my behalf for services rendered if I have dental insurance.

_____ _____

Signature Date

Family Values Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

X Name: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ryan Wratchford, DDS

Telephone: 301-729-6911 Fax: 301-729-6912

E-mail: welcome@familyvaluesdental.com

Address: 772 National Highway LaVale, MD 21502

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

X I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.