Georgetown Comprehensive Dental Care

New Patient Information Form

Thanks for completing this form. If you're not sure how to answer something, just ask when you arrive. Glad to have you aboard!

Knowing more about you, including any health conditions, will help us treat you and keep you healthy.

Please note that payment is due in full at the time of treatment, unless prior arrangements have been approved.

ABOUT YOU

Name _____ Birthdate _____

Address _____ City _____

State _____ Zip _____ Social Security No. (for insurance purposes) _____

Gender _____ Day Phone _____ Text No. _____

Email _____ Employer_____

My 1st and 2nd contact preferences are: ___Phone/Voicemail ___Text ___Email ___US Mail (Wireless charges may apply)

Recall appointment preference: ___ Schedule in advance (at current appointment) ____Send email reminder to schedule ____ I'll call when I'm ready

☐ I give my permission to be contacted about appointments, healthcare issues and billing, as per my preferences.

☐ I give my permission to share appointment, healthcare and billing information with my Secondary Contact (below).

Signature of Patient (or Parent/Guardian) _____ Date _____

Authorization: I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered by Georgetown Comprehensive Dental Care. I authorize the use of this signature form on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that insurance is submitted by this office as a courtesy and I remain responsible for the full amount of the services if insurance does not pay in a timely manner.

SECONDARY CONTACTS

Secondary Contact: ☐ Emergency Contact ☐ Parent/Guardian ☐ Caregiver

Secondary Contact Name: _____ Phone _____ Relation _____

Name of person **paying** for services, if other than patient _____

Address _____ Phone _____

OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ☐ Patient/Legal Guardian refused to sign ☐ Other

Office Manager's Signature _____ Date _____

INSURANCE

Name of Primary Person on Insurance Policy _____ Birthdate _____

That Person's Employer _____

Name of Insurance Company _____ ID _____

Group Name _____ Group ID _____

Claims Address _____ City_____

State _____ Zip _____ Phone Number _____

CURRENT NEEDS AND CONCERNS

Today's Date _____

Purpose of Today's Visit _____

_____

Any Questions You Have for the Dentist _____

_____

DENTAL HISTORY *HONEST ANSWERS ONLY*

Approximate date of your last dentist visit _____

Any significant information about past dental health or previous treatment? _____

_____

How often do you brush? _____ How often do you floss? _____

Check All Items That Apply:

☐ Currently smoke tobacco
☐ Currently chew tobacco
☐ Bite my nails
☐ Suck my thumb or fingers
☐ Other habits affecting my mouth: _____
☐ Previous injury to mouth or chin
☐ Have speech problems
☐ Have had an adverse reaction to medical or dental procedures: _____

OFFICE USE ONLY

I have reviewed this patient's dental and medical history.

Dentist's Signature _____ Date _____

MEDICAL HISTORY

Your Primary Care Physician _____ Phone _____

Approximate Date of Your Last Visit _____

Any Current Serious Illnesses or Recent Operations? _____

List your current medications:

_____

_____

_____

_____

List any allergies (include drug allergies):

_____

_____

_____

Pre-medication required? ☐ Yes ☐ No

Check All Items That Apply:

☐ Currently under physician's care
For _____

☐ Have ever taken Boniva, Fosamax or Bisphosphonates

☐ Currently pregnant
Number of months _____

☐ Have had a blood transfusion
Approx. date _____

☐ There are immunizations or vaccines that I'm due for or should get, but have not yet received
Which _____

Circle Yes or No whether you have had, or are being treated for, any of the following:

Y	N	Heart Attack	Y	N	Heart Disease	Y	N	Angina Pectoris
Y	N	High Blood Pressure	Y	N	Heart Murmur	Y	N	Rheumatic Fever
Y	N	Congenital Heart Lesions	Y	N	Scarlet Fever	Y	N	Artificial Heart Valve
Y	N	Heart Pacemaker	Y	N	Heart Surgery	Y	N	Artificial Joint/Hip/Knee
Y	N	Anemia	Y	N	Stroke	Y	N	Kidney Trouble
Y	N	Ulcers	Y	N	Cosmetic Surgery	Y	N	Hepatitis A (Infectious)
Y	N	Hepatitis B (serum)	Y	N	Liver Disease	Y	N	Yellow Jaundice
Y	N	Blood Transfusion	Y	N	Drug Addiction	Y	N	Hemophilia
Y	N	Fever Blisters	Y	N	Epilepsy or Seizures	Y	N	Fainting or Dizzy Spells
Y	N	Nervousness	Y	N	Psychiatric Treatment	Y	N	Sickle Cell Disease
Y	N	Glaucoma	Y	N	Chemo (Cancer)	Y	N	V.D. (Syphilis, Gonorrhea)
Y	N	Tuberculosis (TB)	Y	N	Asthma	Y	N	Hay Fever
Y	N	Sinus Trouble	Y	N	Allergies or Hives	Y	N	Diabetes
Y	N	Thyroid Disease	Y	N	X-Ray/Cobalt Radiation	Y	N	Arthritis
Y	N	Rheumatism	Y	N	Cortisone Med	Y	N	Pain in Jaw Joints
Y	N	Alcoholism	Y	N	Bleeding Problems	Y	N	Pneumonia
Y	N	Bruise Easily	Y	N	Emphysema	Y	N	HIV Positive

This information is accurate to the best of my knowledge, and I will notify the dentist's office of any significant future health issues or changes to my medical status.

Signature of Patient (or Parent/Guardian) _____ Date _____

OFFICE POLICIES

APPOINTMENTS

We understand your time is valuable and make every effort to accommodate you. Thank you in advance for arriving on time for your scheduled appointments, or notifying us at least 48 hours in advance if you need to reschedule.

After a visit, you'll get a card with your next appointment. We also try to contact you before each visit for confirmation.

We reserve the right to charge a broken appointment fee for when you do not keep your appointment, if you give less than 48 hours (business day) notice, or if you do not respond to our efforts to confirm the appointment. Fees are $50 for a scheduled appointment under an hour in length, and $150 for a scheduled appointment over an hour in length.

PAYMENT

All payments are due in full at the time of service unless prior arrangements have been made and are approved by Georgetown Comprehensive Dental Care.

Some of your treatment may not be covered by your insurance carrier. The cost for such changes will be your responsibility. Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

There will be a fee of $35.00 for any checks returned as Non-Sufficient Funds (NSF).

Patient balances that go unpaid for 30 days or more may incur one or more of the following charges: Interest charges of 1.5% per month; 18% APR collections fees (up to 42% of the full balance); legal fees for collection services.

INSURANCE

We will file most primary insurances at no cost to you as a courtesy.

However, insurance balances are ultimately the patient's responsibility. Balances not paid within 60 days may be billed to you. Please keep the statement we provide, and follow up with your insurance carrier to ensure prompt payment.

Your treatment plan includes our best estimate for coverage based on the information provided by your insurance company. Insurance companies provide a basic, not detailed overview of your benefits and this is **not a guarantee of payment.** Insurance companies may have variations and limitations depending on your specific policy. We please ask that you become familiar with your insurance coverage to avoid any confusion.

Non-covered services, no matter the circumstances, become the patient's responsibility. We will re-file your claim one time after your initial submission, as we do file your insurance as a courtesy to you.

You will be notified of any non-paid dental services. Your payment can be remitted to Georgetown Comprehensive Dental Care if no other insurance payments are forthcoming.

I understand and agree to these office policies.

I have seen, and acknowledge, this office's Notice of Privacy Practices.
Note: *This information is available from office staff, or online at gtcdentalcare.com/privacy*

Signature of Patient (or Parent/Guardian) _____ Date _____