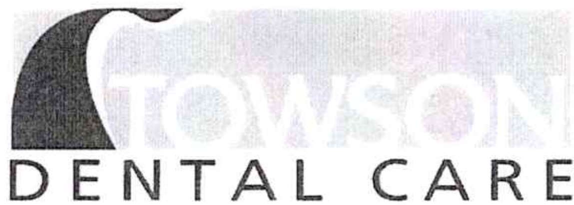

DENTAL CARE

Craig L. Snyder, DDS
300 East Joppa Road, Suite 400, Towson, Maryland 21286
Phone (410) 296-3993 Fax (443) 519-5474
www.TowsonDentalCare.com

Patient Registration and Health History

Patient Information

Today's Date______________

Name: ____
Last Name First Name Middle Initial

I prefer to be called: ____________________ Age: _____

☐ Male ☐ Female Birthdate: ___/ ___/ ___

SS#: ____

Address: ____

City:____

State: _______________________ Zip Code: __________

E-mail Address: _____________________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Separated ☐ Minor ☐ Partnered for ______ years

Home #(_____)__________ Cell#(_____)______________

Work #(_____)_________________ ext _________

Occupation: ____

Employer/ School: ____________________________________

How long there? ______________________________________

Where and when are best times to reach you?

____

Whom may we thank for referring you?

____

Other family members seen by us:

____

____

Person Responsible for Account:________________________

Work # (____)__________ Home # (____)______________

Billing Address: ______________________________________

Relationship: ____________ SS#_______________________

Employer: ____

Emergency Contact

Name: ____________________ Relationship: ________

Home # (____)__________Cell#(___) _______________

Work # (____)__________ Ext _______

Address:____

Spouse Information

His/Her Name: _______________________________________

Employer: ____

SS# _______________ Birth date: ___/ ___/ ___

Dental Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone #: ____________________________

Group # (Plan, Local, or Policy #): __________________

ID #: ____

Insured Name: _______________________________________

Relationship: _______ Insured Birthdate: ___/ ___/ ___

Insured Employer: ____________________________________

Employer's Address: __________________________________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone #: ____________________________

Group # (Plan, Local, or Policy #): __________________

ID #: ____

Insured Name: _______________________________________

Relationship: _______ Insured Birthdate: ___/ ___/ ___

Insured Employer: ____________________________________

Employer's Address: __________________________________

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________________________

Date of last Visit:________ Phone #(_____)____________

Are you currently under the care of a physician?

☐ Yes ☐ No

Please Explain: ______________________________________

____

Your current general health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco? ☐ Yes ☐ No

If yes, what and how much? ___________________________

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many per week? ___________________________

Have you been hospitalized for any reason? ☐ Yes ☐ No
If so, explain: ____________________

Are you taking any prescriptions, over-the-counter or herbal medications? ☐ Yes ☐ No
Please list each one: ____________________

Have you ever taken Fosamax or other medications for osteoporosis? ☐ Y ☐ N

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week # ________
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?
Please circle Y or N

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Acid Reflux	Y	N	High Blood Pressure
Y	N	Alcohol/Drug Abuse	Y	N	HIV+/AIDS
Y	N	Anemia	Y	N	Infective Endocarditis
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valve	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Osteoporosis/ Paget's Disease
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Sexually Transmitted Disease (STD)
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease/Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis			

Please list any serious medical condition(s) that you have ever had:
____

Allergies

Are you allergic to any of the following?
Please circle Y or N

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Latex
Y	N	Clindamycin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Ibuprofen	Y	N	Other

Please list any other drugs/materials you are allergic to:
____

Reason for today's visit? ____________________
Date of last dental visit: ____________________
Former Dentist: ____________________
Date of last dental x-rays: ____________________

Do you require antibiotics before dental treatment?	Y	N
Are you currently in pain?	Y	N
Have you ever had a serious/difficult problem associated with any dental treatment?	Y	N
Have you ever had gum treatment?	Y	N
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?	Y	N
Are you happy with your smile?	Y	N
Would you like a whiter smile?	Y	N
Would you be interested in straighter teeth?	Y	N
Do your gums bleed?	Y	N
Are your teeth sensitive to heat/cold/or anything else?	Y	N

If yes, describe ____________________

Have you lost any teeth?	Y	N

If yes, why? ____________________

Do you have any dental anxiety or fear?	Y	N

Describe ____________________

Do you clench or grind your teeth?	Y	N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor
How many times a week do you floss? ____________
How many times a day do you brush your teeth? ____________
Type of bristles?
☐ Soft ☐ Medium ☐ Hard ☐ Electric Toothbrush

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____
Signature (Guardian if minor) Date

Payment is due in full at time of treatment
unless prior arrangements have been approved.

This office accepts insurance, therefore I understand that I am responsible for payment of the service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature (Guardian if minor) Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: __________ Date: __________

Doctor's Comments: ____________________

Craig L. Snyder, DDS, PA
300 E. Joppa Road, Suite 400
Towson, Maryland 21286
(410) 296-3993
www.towsondentalcare.com

To Dentist:____

____

____

From Patient:______________________________________

DOB____

I authorize Dr._______________________________
to release my dental radiographs to:

Towson Dental Care at info@towsondentalcare.com
Or call 410-293-3993

Patient Signature:

_______________________________ **Date**_______________

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Practice Guidelines and Financial Policy

WELCOME to our practice, it is our pleasure to have you as our patient. Our mission at Towson Dental Care is to provide a quality dental experience in a comfortable and caring manner, helping each patient achieve the healthy beautiful smile they deserve. We are proud of our commitment to our patients, our community and the environment. Our knowledgeable and highly trained team is dedicated to excellence in comprehensive dental care while building lifelong relationships.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the information below or insurance coverage, please do not hesitate to ask...we are here to help.

Appointment Guidelines

- ☐ In the event that you are unable to keep your reserved appointment time, we ask that you give us **48 hours notice**, so that we may offer this time to another patient in need of care. As long as we receive this notice we can guarantee there will not be a charge. If something unforeseen should occur, the fee for a missed appointment is $50 per appointment hour. This fee will be assessed on a case-by-case basis.

Insurance Benefits

- ☐ If you are a patient with dental benefits, it is important to remember your dental plan is a contract between you, your employer, and your dental insurance carrier. Dental insurance is a limited benefit and can have specific coverages and exclusions. We accept assignment of benefits as a courtesy to our patients. We submit an insurance claim for services as they are rendered. Therefore accurate insurance information is necessary for correct billing. The estimate provided by this office is to be considered a guideline, not a quote, until the final insurance payment is received. **Ultimately you are responsible for all the cost of treatment.** **<u>All unpaid insurance balances are due and payable from the patient after 60 days.</u>**

Financial Understanding and Guidelines

- ☐ **<u>Private Payments and Insurance Deductibles and Estimated Co-Payments are due in full at the time service is rendered.</u>** We accept Cash, Checks, MasterCard, VISA, and Discover Card. Outside financing is available through Care Credit upon approval. Returned checks and outstanding balances over 60 days are subject to collection fees. *<u>Submission to treatment implies your consent to terms of this agreement.</u>*

Changes in Personal Information

- ☐ Please notify us of any changes in your medical history, any changes in your medications, telephone numbers, address or insurance information as soon as possible so that we may keep your file information current and accurate.

______ (Initials) **I acknowledge that I have read the HIPAA Notice of Privacy Practices.**
A copy is available for you take with you upon request.

Patient Signature____ Date: ____________________

Print Name____