Lucia O. Ditch, D.D.S.

PATIENT INFORMATION

Name_____Age_____Sex □M □F Home Phone_____
Address_____Apt#_____Work Phone_____
City_____State_____Zip_____Cell Phone_____
DOB_____SSN_____E-Mail_____
Employer/Occupation_____Emergency contact name/#_____
Any family members in this practice? □Yes □No Name_____
How did you hear about us?_____

PRIMARY INSURANCE

Name of Policy Holder_____DOB_____SSN_____
Insurance Name_____Subscriber ID#_____Group#_____

SECONDARY INSURANCE

Name of Policy Holder_____DOB_____SSN_____
Insurance Name_____Subscriber ID#_____Group#_____

PATIENT TREATMENT CONSENT

I authorize the dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist(s) to preform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. Some teeth may have hidden decay, or affected nerves requiring more extensive treatment which could lead to additional charges.

APPOINTMENT POLICY

Cancelled or broken appointments without 24hrs notice will be charged **$50 per half hour**. If there are numerous broken and cancellations on the account, this may be grounds for termination from the practice. We are unable to provide the quality of care needed when appointments are broken.

FINANCIAL POLICY

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I agree that the charges for services shall be as billed unless objected to, by me in writing, within the time payment is due. A fee of **$35** will be charged for any returned checks. After one returned check we can no longer accept checks only cash, credit card or money orders. I agree that a waiver of any breach any time or condition hereunder shall not constitute a waiver of any further term or condition and I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. **Accounts sent to a third party for collection will incur a charge that is based on 50% of your outstanding balance.**

- **Patients with Dental Insurance** must make sure that we accept their insurance. This office does not participate with every plan and may change participation during the year. We will accept assignment of benefits and collect the patient estimated portion at time of service. The office will file the insurance claim as a courtesy and to help speed up payment of claim. If we have not received payment 90 days after claim has been filed, the balance becomes responsibility of the patient. Our office will not assume responsibility for the lack of benefits paid. Your insurance company states “this is not a guarantee of benefits”, therefore we cannot offer a guarantee they will pay. This form authorizes the practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation “SIGNATURE ON FILE.” I authorize my dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested. If you have concerns about this issue you can call your insurance company for details or refer to your policy manual prior to any dental treatment.
- **Payment Plans** are available for patients undergoing treatment that require several visits. You must make an appropriate down payment with balance due upon completion of treatment.

Arrangements must be made in advance with the office financial coordinator.

I understand I am responsible for any portion not paid by my insurance company regardless of an estimate I may have been quoted.I grant my permission to you or your assignees, to telephone me to discuss this statement or my treatment. I have read and understand the above information and agree with the terms and conditions.

_____ _____
Patient/Financial Responsible Guardian Date

6201 Greenbelt Rd. Suite M5 College Park, MD 20740 P(301)345-5422 F(301)301-345-7231

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HIPPA ACKNOWLEDGMENT

I understand that, under the Health Insurance portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing more complete description of the uses and disclosure of my health information. I have been given the right to review such notice of Privacy Practice prior to signing this consent. I understand that this organization has the right to review it Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Patient/Financial Responsible Guardian Date

HIPAA DESIGNATION OF PERSONAL REPRESENTATIVE

You may designate a personal representative who may act in your behalf in making decisions relating to health care,which includes treatment and payment issues. This individual can be a family member, friend,lawyer or unrelated party. Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete form.

I authorize the office of: **Dr. Lucia O. Ditch, D.D.S**

To release information relating to the care and payment of:

- Patient Name:_____Date of Birth:_____Chart#:_____
- Address:_____Phone#:_____

I hereby designate the following individual(s) as my personal representative:

1. Name of individual:_____Phone#_____
   Address:_____
2. Name of individual:_____Phone#_____
   Address:_____

_____ _____

Patient/Financial Responsible Guardian Date

Lucia O. Ditch, D.D.S.

MEDICAL/DENTAL HISTORY FORM

Patient Name:_____ Date of Birth:_____

Are you currently being treated by a physician? ☐Yes ☐No

Physicians Name/Address/Phone#:_____

Do you need to take antibiotic pre-medication prior to dental appointment? ☐Yes ☐No

Pharmacy Name/Phone#:_____

MEDICAL HISTORY

Information that you may feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

***Please check box accordingly:**

Anemia	☐Yes ☐No	Pacemaker	☐Yes ☐No
Arthritis	☐Yes ☐No	Respiratory Problems	☐Yes ☐No
Artificial Joints(Hip/Knee)	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Asthma	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Blood Disease	☐Yes ☐No	Sexually Transmitted Diseases	☐Yes ☐No
Blood Pressure-High	☐Yes ☐No	Stomach Problems	☐Yes ☐No
Blood Pressure-Low	☐Yes ☐No	Stroke / Heart Attack	☐Yes ☐No
Cancer/Tumor	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemotherapy/Radiation	☐Yes ☐No	Ulcers	☐Yes ☐No
Depression	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Bypass	☐Yes ☐No
Dizziness/Fainting	☐Yes ☐No	Angina	☐Yes ☐No
Epilepsy	☐Yes ☐No	Sickle Cell trait	☐Yes ☐No
Excessive Bleeding	☐Yes ☐No	Leukemia	☐Yes ☐No
Glaucoma	☐Yes ☐No	Bronchitis	☐Yes ☐No
Growths	☐Yes ☐No	Emphysema	☐Yes ☐No
Hay Fever	☐Yes ☐No	Fibromyalgia	☐Yes ☐No
Head Injuries	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Heart Disease	☐Yes ☐No	Artificial Heart Valves	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Drug Abuse	☐Yes ☐No
Hepatitis/Jaundice	☐Yes ☐No	Heart Surgery	☐Yes ☐No
HIV/AIDS	☐Yes ☐No	Lupus	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Tobacco/Alcohol use	☐Yes ☐No
Liver Disease	☐Yes ☐No	Cholesterol	☐Yes ☐No
Mental Disorder	☐Yes ☐No	**Female:** Taking Birth Control	☐Yes ☐No
Other:_____		Pregnant/ Planning	☐Yes ☐No
		Nursing	☐Yes ☐No

Allergies to :

Aspirin	☐Yes ☐No	Latex	☐Yes ☐No
Codeine	☐Yes ☐No	Penicillin	☐Yes ☐No
Erythromycin	☐Yes ☐No	Sulfa	☐Yes ☐No
Local Anesthetic	☐Yes ☐No	Amoxicillin	☐Yes ☐No

Other:_____

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MEDICATIONS: Are you presently taking any medications or pills? ☐Yes ☐No
List: _____for_____
_____for_____
_____for_____
_____for_____
_____for_____

Is there any condition relating to your medical history that has not been mentioned? ☐Yes ☐No

Explain:_____

DENTAL HISTORY

Do your gums bleed easily? ☐Yes ☐No
Do you suffer from chronic bad breath? ☐Yes ☐No
Do you have jaw joint cracking or pain? ☐Yes ☐No
What was the purpose of your last dental visit?_____
When was the last time you had a dental cleaning?_____
How often do you brush?_____Floss?_____

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Patient/Guardian Signature_____Date_____Dr./Hyg.Signature_____

YEARLY REVIEW OF PATIENT MEDICAL HISTORY

Changes	List	Date	Pt/Guard. Sign	Dr./Hyg. Sign
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				
☐Yes ☐No				

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