PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

EMERGENCY CONTACT: _____

EMER. CONTACT PHONE#: _____

REFERRED BY: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Dechter & Moy, DDS, LLC

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

ALAN DECHTER DDS
MATTHEW MOY DDS
DENTISTRY

Why Do I Need X-rays?
Radiographic or X-ray examinations provide your dentist with an important tool that shows the condition of your teeth, its roots, jaw placement and the overall composition of your facial bones. X-rays can help your dentist determine the presence or degree of periodontal disease, abscesses, and many abnormal growths, such as cysts and tumors. X-rays also can show the exact location of impacted and unerupted teeth. They can pinpoint the location of cavities and other signs of disease that may not be possible to detect through a visual examination.

Do all patients have X-rays taken every six months?
No. Your radiographic schedule is based on the dentist's assessment. In most cases, new patients require a full mouth set of X-rays to evaluate oral health status, including any underlying signs of gum disease and for future comparison. Follow-up patients may require X-rays to monitor their gum condition or their chance of tooth decay.

What kind of X-rays does my dentist usually take?
Typically, most dental patients have "periapical" or "bitewing" radiographs taken. Bitewing X-rays typically determine the presence of decay in between teeth, while periapical X-rays show root structure, bone levels, cysts and abscesses.

My dentist has prescribed a "panoramic radiograph." What is that?
A panoramic radiograph allows your dentist to see the entire structure of your mouth in a single image. This X-ray reveals all of your upper and lower teeth and parts of your jaw. It will also show any abnormal growths, such as cysts and tumors.

Why do I need both types of X-rays?
What is apparent through one type of X-ray often is not visible on another. The panoramic X-ray will give your dentist a general and comprehensive view of your entire mouth on a single film, which a Full Mouth Series, periapical or bitewing X-ray cannot show. These X-rays make it easier for your dentist to see decay or cavities between your teeth. X-rays are not prescribed indiscriminately.

Should I be concerned about exposure to radiation?
All health care providers are sensitive to patients' concerns about exposure to radiation. Your dentist has been trained to prescribe radiographs when they are appropriate and to tailor radiographic schedules to each patient's individual needs. By using state-of-the-art technology your dentist knows which techniques, procedures and X-ray films can minimize your exposure to radiation.

I **accept** recommended x-ray procedures

Signature _____ Date _____

If you refuse or choose to wait on x-rays in our office it is with the understanding that it is in direct opposition to our recommendations. In some cases, I may ask you to seek services at an office that would agree to treat without radiographic examination.

I **decline** recommended x-ray procedures.

Signature _____ Date _____

12900 Georgia Avenue • Silver Spring, MD 20906 • DechterMoy@verizon.net
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ALAN DECHTER DDS
MATTHEW MOY DDS
DENTISTRY

AUTHORIZATION AND RELEASE

I hereby authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered during the time period of my Dental care to third party payors and/or other health practitioners involved in my treatment by any method, including electronic transfer.
I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge.
I authorize and request my insurance company to pay directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ *State Driver's License attached*
_____ Insurance Card attached

Patient: _____ DOB: _____ Date:_____

Signature _____
(If other than the responsible party)

Responsible Party: _____ Signature _____

Dependent family members also covered by this acknowledgement:

_____ _____ _____

PRIVACY AUTHORIZATION AND CONSENT (*For patients over 18yrs+*) **TO BE FILLED OUT BY PATIENT ONLY!**

Do you give our office permission to discuss your medical/dental information with family members?

Yes___ No___ (If yes, please provide their name(s) and phone number(s) below)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

May we leave personal medical/dental information and appointment details on your phone voicemail and/or e-mail?

Yes___ No___ (If yes, please check all that apply) Home___ Cell___ Text____Work___ E-mail___

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DENTISTRY

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

* Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
* Obtain payment from third-party payers for my health care services
* Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Full Name: _____(if other than the responsible party)

DOB: _____

Patient Signature _____

Responsible Party: _____

Signature _____

Dependent family members also covered by this acknowledgement:

_____ _____ _____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason

__ The patient refused to sign
__ Emergency situation
__ Communication barriers
__ Other (please specify)

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ALAN DECHTER DDS
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DENTISTRY

APPOINTMENT POLICY

We make every effort to see all patients on time and request that you extend the same courtesy to us. Appointment times are reserved exclusively for **you** and will be scheduled at times best suited for the treatment involved. Any changes in appointments greatly affect other patients. We require a minimum notice of **24 hours** for any appointment changes. A fee of $45.00 per hour may be charged for broken appointments or short notice changes. This fee must be paid prior to any future treatment.

FINANCIAL POLICY

In our efforts to keep dental costs at a minimum while maintaining a high level of professional care, we have established the following payment policies:

1. **Patients Without Insurance Coverage:**

Payment is Expected At The Time of Treatment and May be Paid for By:

Credit Card - VISA, DISCOVER, AMERICAN EXPRESS, or MASTERCARD
Cash, Carecredit and Lending Club

2. **Patients With Insurance Coverage**

Insurance Plans are accepted providing that verification of eligibility has been made prior to the appointment and that we can accept the Assignment of Benefits.

**** Deductible and Estimated Patient Portions not covered by Insurance will be collected at the time services are rendered.**

All fees related to treatment are the full responsibility of the patient. In the event that payment is not received within 60 days from treatment or the insurance payment varies from the estimated portion, the **remaining balance** will become the responsibility of the patient.

Payment in full is required for accounts sent to collections before. Insurance payments will be sent to patient.

3. Treatment consisting of several visits will require an appropriate down payment with balance due upon completion.
4. Payment Plans are available and arrangements **must be made in advance** of treatment. Providing that credit qualifications are met. Payment plans will require an appropriate down payment and may be subject to monthly finance charges.
5. **Account Balances Are Due Upon A Receipt Of Statement From Our Office.**

Account balances not paid within **25 days** from the statement date may be subject to a service charge of **1.5%** per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance.

6. Patient is responsible for any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect account collection or future outstanding accounts.
7. A fee of $25.00 will be charged for any Returned Checks.

We hope this information is helpful in answering some of the questions you may have regarding our office policies. Please feel free to discuss any questions you may have with us..

I have fully read the above information and agree with the terms and conditions.

_____ Date: _____
Patient Name & Signature (if other than the responsible party)

_____
Responsible Party: Name & Signature

Dependent family members also covered by this acknowledgement:

_____ _____ _____

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