PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☒ M ☐ F Married: ☒ Y ☐ N

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☒ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☒ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☒ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) ☐ Non Student ☐ Full Time ☐ Part Time

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☒

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☒ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:
EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Joint Replacement	☐	☐	Ulcers

Other conditions not listed above:

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

Patient/Guardian Signature
Date: 05/14/2024

_____

Notice of Privacy Practices

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. If you are referred to another practitioner, your health information may be provided in the event you schedule an appointment with that provider of care.

Persons involved in care: We may use or disclose health information to notify or assist in notification of a Family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information we will provider you with the opportunity to object. In the event of an emergency, we will disclose health information, using our professional Judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing: We will not use your health information for marketing communicating.

Required by law: We may use or disclose your health information when we are required to do so by law.

Payment: We may use & disclose your health information to obtain payment for services we provide to you. Disclosure to third party payors will occur with your request. Provision of insurance information by you will be considered permission to provide information to your insurance carrier. A request to provide information to your insurance carrier can be altered, in writing, at any time.

Questions and Concerns: If you have a question or concern regarding our privacy policy. Please contact: Bruce Auslander, D.D.S Address: 2658 Brandermill Blvd Gambrills, MD 21054, Phone: 301-262-2125

Please assist us in protecting your privacy by providing your preferences (more than one may apply)

1. **Please choose how you would like to confirm appointments:**

   ___ Do not confirm __ Phone call only __ Text message

2. **Can we leave a voicemail?** __ Yes __ No
3. **Do you give any family members accessed to PERSONAL HEALTH INFORMATION (PHI)?** __Yes __No
   Name: _____ **Relation**: _____
4. **Person Health Information Record Release**: ___ **Verbal Release** __ **Written release only**
   Name: _____ may pick up prescriptions, x-rays or other forms on my behalf.

Name: _____ Signature: _____ Date: _____
Guardian: _____ Signature: _____ Date: _____

Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fee for treatments, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and persevere our relationship.

- **Payment for services is due at the time treatment is rendered.** If you have dental insurance, we are here to help receive maximum allowable benefits. In order to achieve this goal, we need your assistance in understanding of our payment policies. We will be happy to process your insurance claims for reimbursement as well as accept insurance assignment from your insurances we are participating providers with. **Insurance is not a guarantee of benefit or payments. If for any reason your insurance denies a claim you will be responsible for the balance.**

- A **cancellation** is considered late when the appointment is cancelled less than 24 hours before the appointed time. A **broken appointment** is when a patient misses an appointment without cancelling. **In either case, we will charge the patient a $75 missed appointment fee.**

- Returned checks due to insufficient funds or closed accounts will have a $35 charge.

- If your account must be placed in the hands of a third party for collections, your account will be charged 1/3 of the total balance of the collection fee.

If you have any questions about the above information or any uncertainty regarding your insurance, please do not hesitate to ask.

____ I have read the above conditions of treatment and payment and agree to the policies.

Signature of guarantor or payment/responsible party: _____

Signature: _____ Date: _____

Relationship: _____

Bruce Auslander, D.D.S
2658 Brandermill Blvd
Gambrills, MD 21054
301-262-2125

Financial Agreement

Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fee for treatments, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and persevere our relationship.

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