Adam J. Frieder, DDS, LLC

401 W. Seventh St., Frederick, Md. 21701 (301) 662-7766

We'd like to get to know you better! **Date**_____

PERSONAL INFORMATION

Patient Name_____ Nickname_____ Sex_____

Birth date_____ Social Security #_____-_____-_____ Occupation_____

Person Responsible for Account _____ Relationship _____

Social Security #_____-_____-_____ Birth date_____ Driver's License #_____

Patient Address_____

Billing Address_____

Home Phone _____ Business Phone _____

Mobile Phone _____ __ E-Mail Address _____

Responsible Party's Phone_____ Referred by _____

From the phone numbers above, please circle the best one for us to reach you during the daytime.

EMPLOYER AND INSURANCE INFORMATION

Please provide office with a copy of your insurance card.

Name of primary insurance holder_____ Relationship_____

Insurance Company _____ Group #_____

Ins. Co. Phone _____ Ins. Co. Address_____

MEDICAL HEALTH

Name and address of physician_____
Phone # of physician _____
Have you been under a physician's care during the past 2 years? _____
For_____
Have you been treated in the hospital in the last two years? _____
For _____
Have you ever had major surgery? _____
If female, are you on hormones or birth control? ___ Are you pregnant or nursing? _____
Have you ever had a blood test for hepatitis? ____ Were you vaccinated? _____
Have you ever had canker or cold sores on your lips, tongue, gums or body? _____
Are you now taking, or have you taken any prescription drugs during the past year? _____
Please list: _____
_____
Are you allergic to? _____Penicillin _____Codeine _____Local Anesthetics ____Latex
Allergies to Other Medications _____
Have you been out of the country within the last two years? _____

Have you had, or do you now have:

	Yes	No		Yes	No
High/low blood pressure	___	___			
AIDS	___	___	Herpes	___	___
Allergies	___	___	Jaundice	___	___
Anemia	___	___	Joint Replacement	___	___
Angina	___	___	Kidney Disease	___	___
Arthritis	___	___	Liver Disease	___	___
Artificial heart valves	___	___	Organ Transplant	___	___
Artificial joints	___	___	Pacemaker	___	___
Asthma	___	___	Prolonged bleeding	___	___
Cancer	___	___	Prolonged cough	___	___
Chemotherapy	___	___	Psychiatric treatment	___	___
Congenital heart lesions	___	___	Radiology therapy	___	___
Diabetes	___	___	Rheumatic fever	___	___
Drug Dependency	___	___	Sickle Cell Anemia	___	___
Easily bruised	___	___	Sinus/Hay Fever	___	___
Epilepsy/Neurological problems	___	___	Stroke	___	___
Fainting or dizzy spells	___	___	Thyroid Disease	___	___
Glaucoma or eye problems	___	___	Tonsillitis	.___	___
Heart disease	___	___	Tuberculosis/Lung disease	___	___
Heart murmur	___	___	Ulcers	___	___
Hepatitis	___	___	Venereal Disease	___	___

Have you any disease, condition, or problem not previously listed? _____
_____
_

DENTAL HEALTH

When was your last dental visit? _____ Who did you see?_____
How often did you see your dentist?_____
Are you having any dental problems that require immediate attention? _____
Do any of the following cause tooth discomfort:
Hot___ Cold___ Sweets___ Chewing___
How often do you brush your teeth? _____ How often do you floss?_____
Do your gums bleed while cleaning? _____
Do your gums ever feel tender or swollen? _____
Have you had periodontal treatment? _____
Do you clench or grind your teeth? _____
Do your jaws ever feel tired or ache? _____ Does it ever click or pop? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you have frequent headaches? _____ Ear aches? _____
Have you ever had orthodontic treatment (i.e. braces?)_____ When? _____
Do you lose or break fillings?_____ Do you usually have many cavities? _____
Do you have any loose teeth? ____Cracked or broken teeth? _____Food traps? _____
Do you have any missing teeth? _____ Have they been replaced? _____
If so, how? ___Fixed bridge ___Removable Partial ___Full denture ___Implant
Are you comfortable with the replacement? Please describe_____
_____

Do you have an unpleasant taste or odor in your mouth? _____ Do you smoke? _____ How much?_____
Do you frequently snack between meals or chew gum? _____ Have you ever been instructed regarding proper home care? _____Has fear or discomfort kept you from regular dental visits? _____
Is there anything you would like to share with us that we have not mentioned? _____
_____

PERSONAL SMILE EVALUATION

Please take a moment to answer these questions about your smile:

1) On a scale of 1-10 (1 being the lowest), rate your teeth and smile_____
2) Are your teeth crooked, crowded or worn? If so, are you concerned? _____
3) Do you have any spaces between your teeth that bother you? _____
4) Do you like the color of your teeth? _____
5) Have you ever considered how you'd feel with a brighter smile? _____
6) Do you like the shape of your teeth? _____
7) What changes would you like to make with the appearance of your smile? _____
   _____
8) Is there anything you'd like to share with us that we have not mentioned? _____
   _____

If we may assist you or answer any concerns you may have—please ask! We want to make your dental experience as pleasant as possible!

The above information is true and complete to the best of my knowledge. I consent to the treatment requested by me covering all aspects of routine dental care, including administration of x-rays, photos, local anesthetics, sedatives, nitrous oxide or combination. I consent to have an HIV or hepatitis test paid for by Dr. Frieder should any accidental exposures to any of the clinical personnel occur. I understand that perfect results cannot be guaranteed.

Signature_____ Date _____

CONSENT FORM FOR HYGIENE

I agree to occasionally receive dental hygiene services without a dentist in the office if I have been examined by Dr. Frieder within the past seven months. I understand a prescription for these services is written in my chart.

Signature of Patient _____ Date _____

Signature of Hygienist _____ Date _____

Consent for a Minor or Incompetent Adult

I, _____, as custodial parent or guardian of _____, consent to the occasional delivery of hygiene services to _____ without a dentist present if she/he has been seen by Dr. Frieder within the last seven months. I am aware that a prescription for dental hygiene services is written in the patient's chart.

Signature of Parent/Guardian: _____ Date _____

Signature of Hygienist: _____ Date _____

Adam J. Frieder, DDS, LLC

Family and Cosmetic Dentistry

OFFICE FINANCIAL POLICY

Thank you for choosing our practice for your dental care. We are committed to you and the success of your treatment.

Please understand that all charges for treatment are your responsibility. Out of courtesy for our patients, we will assist you with your insurance claims. All co-payments are due in full at the time of service. For your convenience, we accept cash, check, Visa, Mastercard and American Express. Interest will be charged monthly for accounts that are past due. If it becomes necessary to send your account to our attorney, you will be responsible for all costs involved with the collection process. This will include all court costs and attorney fees.

If you will be considering using your charge card, please provide the following information: Card Number _____ Exp. Date _____

If there is a delinquent balance on your account and a charge card is on file, this outstanding balance may be applied to your card.

We will accept assignment of your insurance benefits as long as we are able to verify coverage. The balance not paid by your insurance carrier is your responsibility. We will process your claims, provided you are able to give us accurate insurance information. It is your responsibility to inform us of any changes in your coverage. Your insurance policy is a contract between you and your carrier. Please be aware that some and perhaps all of the services may not be covered by your insurance. If a service is not covered, it is your responsibility.

Please help us serve you and our other patients by keeping your reserved appointments. Appointments that are missed or changed without 48 hours prior notice may be subject to a charge based on the length of that missed appointment. A transfer fee may also be applied to your account in the event you leave our practice.

Thank you for taking the time to read and understand our office policy. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions or concerns.

Signature: _____ Date _____

Our Financial Options

Thank you for choosing our practice for your dental care. We are committed to you and your dental health. We offer several financial options to assist you with the care you need, deserve, and desire. Please review and feel free to contact the office. We would be happy to answer any questions you may have concerning financial arrangements.

We Accept:

- Cash
- Personal Checks
- Visa, MasterCard, or American Express
- Monthly deduction directly from your charge card or bank card
- Post-dated checks after down payment to begin treatment

We also can offer applications for outside financial institutions which provide affordable credit:

- **CareCredit**
  1) Financing for treatment from $1.00 to more than $25,000.00
  2) Comprehensive range of payment plans including plans with 3, 6, and 12 months' interest free
  3) Low-interest extended payment plan options
  4) Revolving line of credit that can be used by the entire family for ongoing treatment without having to reapply
  5) No upfront costs, pre-payment penalties or annual fees

  Contact a representative at 1-800-300-3046 to learn more about the Options available, or visit them at www.carecredit.com

- **ChaseHealthAdvance**
  1) No down payment required
  2) Payment plans to fit your budget
  3) No pre-payment penalties

  You can speak directly to a representative by calling 800-510-5638 Visit them at www.chasehealthadvance.com