City Place Dental

8780 Georgia Avenue, Silver Spring, MD 20910 Phone: (301) 585-1515

Please complete Dental History information on reverse side

PATIENT INFORMATION

PATIENT'S NAME (Last, First, M.I.):

BIRTIMATE: AGE: SOCIAL SECURITY NO.:

EMAIL AND CELL PHONE:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

REASON FOR THIS VISIT:

PHYSICIAN NAME: PHONE NO.:

PHYSICIAN ADDRESS:

IN CASE OF EMERGENCY NOTIFY: RELATIONSHIP:

RESPONSIBLE PARTY INFORMATION

NAME (Last, First, M.I.): MARITAL STATUS:

ADDRESS Street, City, State, Zip):

HOW LONG AT THIS ADDRESS?	SPCIAL SECURITY NO.:
HOME PHONE:	WORK PHONE:
BIRTIMATE:	DRIVER'S LICENSE NO.:
RELATION TO PATIENT:	OCCUPATION:
EMPLOYER:	NO. YEARS EMPLOYED:

MEDICAL HISTORY Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible health care to you (or your child), it is necessary to have the following information. Have you (the patient) ever had or do you now have the following, if yes, please indicate "yes" and circle or write in illness or condition.

	YES	NO		YES	NO
Asthma, hay fever, sinusitis, or other allergies			Communicable disease: tuberculosis, herpes or venereal		
Allergy to penicillin, aspirin, local or general anesthetic, or other drugs or materials such as latex (in gloves); Specify:			Acquired Immune Deficiency Syndrome (AIDS)/A.R.C./HIV positive		
Blood pressure or heart problems			Do any wounds heal slowly or present complications?		
Rheumatic fever or heart murmur or mitral valve prolapse			Are you presently taking any medicine? Specify:		
Pacemaker or open-heart surgery or heart valve replacement			Are you presently under the care of a physician?		
Diabetes, liver, kidney, thyroid, or lung problems			When was your last physical exam?		
Ulcer or stomach problems			Have you ever been hospitalized? Date: Reason:		
Hepatitis or jaundice			Have you had any x-ray treatments or chemotherapy?		
Epilepsy or nervous disorders			Any other illness?		
Bleeding or clotting disorders			Are you presently on a diet?		
Arthritis or hip replacement surgery or prosthetic joint replacement			Are you taking birth control pills? Are you pregnant		

Patient/Guardian Signature Date

Date

Doctor's Signature

CERTIFICATION OF PAYMENT

I accept responsibility for paying all balances due at the time of service. In the event the account becomes delinquent, I accept responsibility for paying interest and collection fees arising as a result of my failure or delinquency in settling this debt, as well as all legal fees incurred pursuant to obtaining payment.

Patient/Guardian Signature Date Doctor's Signature Date

Patient Responsibility Agreement

Notice to All Patients:

The services that we provide are of the highest quality and for your health benefit. Not all procedures are covered by your particular insurance plan. If your particular plan does not cover a procedure, it does NOT mean that you do not need that service. Only providing services covered by your insurance may lead to malpractice. Any service or portion of service that is excluded from your insurance plan, you are responsible for paying. As a patient of our practice you must agree to these terms.

Additionally, patients are responsible for scheduling their appointments for when it is most convenient for them. If you are unable to keep your appointment, please give the courtesy of 24 hours notice. Failure to provide this courtesy will lead to a cancellation fee of $35.00 per hour and $75.00 per hour scheduled.

Once again thank you very much for choosing our dental office

Sincerely,

City Place Dental

Patient/Guardian Signature Date