18544 Office Park Drive,
Gaithersburg, MD 20879
(301) 548-8888

11300 Veirs Mill Road
Wheaton, Maryland 20906
(301) 245-3915

# NEW PATIENT FORM

Patient Name: ______________________________ Today's Date: ____________

______________________________
Address Apt# City State/Zip Code

Home Phone: ____________ Work Phone: ____________

Cell Phone: ____________ Email: ____________

Marital Status: □Single □Married □Other Sex: □Female □Male

Social Security #:_____-_____-_____ Date of Birth: ___/___/___

Responsible Party: ______________________ Relationship to patient: ____________

______________________________
Address Apt# City State/Zip Code

Social Security #:_____-_____-_____ ______________________
Name of Insurance Carrier

How did you hear about our office: ______________________

For the following questions, circle ***Yes*** or ***No***, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health?__________ Yes No
2. Have there been any changes in your health within the past year?__________ Yes No
3. Are you under the care of a physician now?__________ Yes No
4. Have you had any serious illness, operations, or been hospitalized in the past 5 years?__________ Yes No
5. Are you taking any medicine(s) including non-prescription medicine?__________ Yes No
   If so, which ones and for what reason?__________
6. Do you have or have had any of the following diseases or heart problems:
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease?__________ Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary occlusion, high blood pressure, arteriosclerosis, stroke)__________ Yes No
   c. Diabetes__________ Yes No
   d. Hepatitis, jaundice, or liver disease__________ Yes No
   e. Respiratory problems, emphysema, bronchitis, asthma etc__________ Yes No
   f. Arthritis or painful, swollen joints__________ Yes No
   g. Sexually transmitted diseases__________ Yes No
   h. Problems of the Immune System__________ Yes No
7. Have you had abnormal bleeding?__________ Yes No
   a. Have you ever required blood transfusion?__________ Yes No
8. Are you allergic or have you had a reaction to:
   a. Local anesthetics__________ Yes No
   b. Penicillin or other antibiotics__________ Yes No
   c. Aspirin__________ Yes No
   d. Codeine or other narcotics__________ Yes No
   e. Latex__________ Yes No
9. Have you had any serious trouble with any previous dental treatment?__________ Yes No
   If so, explain:__________
10. Do you have any disease, condition, or problem not listed above that you think we should know?__________ Yes No
11. Are you pregnant?__________ Yes No
12. Are you nursing?__________ Yes No

With signing this form I give permission to the participating dentist to review my Medical History Form, and perform an examination, take all necessary x-rays, and complete all minor procedures as needed.

I further understand that individual reactions to the treatment can not be predicted, and if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I understand that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, and reporting to the office any changes in health status as soon as possible.

Insurance benefits are merely an estimate of coverage, and NOT a guarantee of payment. The person responsible for this account will be held liable for any and all remaining amounts the insurance company does not cover. If it becomes necessary to forward this account to a third party for collections, the responsible party is accountable for all fees incurred in the collection process in addition to the delinquent amount.

Any dispute, controversy, or claim arising from care provided by Wheaton Dental Center under this agreement, including any claim related to injury or medical malpractice shall be resolved exclusively by binding and confidential arbitration. Arbitrators will be selected pursuant to the current Rules of Procedure for the American Health Lawyers Association.

I certify that I have read and I understand what is above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or other staff member responsible for any errors or omissions that I may have in the completion of this form.

Responsible party's signature ______________________ Today's date ______________________

Thank you for filling out this form completely. The information you have provided will help us serve you more effectively and efficiently. If you have any questions at any time, please ask. We are always happy to help

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Dental management considerations:

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______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Signature of Dentist ______________________ Today's date ______________________