Patient Information:

Name _____ (First / MI / Last) Age _____ Sex _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Birthdate _____ (Month / Day / Year) SSN _____ - _____ - _____

Employer / Occupation _____ Address _____

In case of emergency, contact: _____ Relationship _____ Phone ( ) _____

Are any of your family members patients of this practice? ❑ Yes ❑ No Name _____ Relationship _____

Home Phone ( ) _____

Work Phone ( ) _____

Other Phone ( ) _____

Email: _____

If the person responsible for the account is different than the patient, please fill in this section:

Name _____ (First / MI / Last) Relationship _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Birthdate _____ (Month / Day / Year) SSN _____ - _____ - _____

Home Phone ( ) _____

Work Phone ( ) _____

Employer _____

Address _____

Primary Dental Insurance (Leave blank only if no dental benefits)

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Group No. _____

Policy Number _____

Name of insured if different than patient:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Secondary Dental Insurance

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Group No. _____

Policy Number _____

Name of insured if different than patient:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Dental History

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of? _____

What was the purpose of your last dental appointment? _____ When was that? _____

When was the last time you had a dental cleaning? _____ Name of previous dentist? _____

When was the last time you had dental x-rays? _____ Why, which teeth? _____

How would you describe your dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you think you have any decay or cavities? ❑ Yes ❑ No How often do you brush? _____

Do your gums bleed easily when brushing or flossing? ❑ Yes ❑ No How often do you floss? _____

Do you suffer from chronic bad breath or bad taste? ❑ Yes ❑ No

Do you have any jaw joint cracking or pain? ❑ Yes ❑ No

Whom may we thank for referring you to our office? _____

Patient Treatment Consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1½% per month.

Patient / Parent or Guardian Signature: _____ **Date:** _____

DARYL B. WITT D.D.S.

FAMILY DENTISTRY

P.O. BOX 5066

LAYTONSVILLE, MD. 20882

PHONE: 301-977-8855

FAX: 301-977-8856

OFFICE POLICY

BILLING LATE FEE: After 60 days a $5.00 rebilling fee will be added each month until account is paid in full or a payment plan is adopted.

AFTER 2 NO SHOWS OR NO CALL TO CANCEL: A $50.00 fee will be charged to your account.

AFTER 3 LATE CANCELS: A $35.00 fee will be charged to your account.

FOR EVERY APPOINTMENT EXCEPT CLEANING AND EXAM: A same day payment will be made to cover co-pays and deductibles.

PAST DUE BALANCES OVER 90 DAYS: Must be paid in full before any additional appointments are made unless prior arrangements were /are in place.

LATE APPOINTMENTS: If you are more than 15 minutes late, anticipate having to reschedule.

PLEASE SIGN AND DATE ACKNOWLEDGING RECEIPT OF THIS POLICY AND HIPPA POLICY.

Signed_____

Date_____