Towson Center for Dental Implants and Periodontics

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REGISTRATION

Patient's Name_____ Date_____

Address_____ City_____ State_____ Zip Code_____

Telephone: Home_____ Work_____

Cellular_____ Fax_____ E-mail Address:_____

Emergency Contact_____ Phone_____ Relationship_____

Martial Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Minor _____

Date of Birth_____ Age_____ Social Security No._____

Employer_____ Occupation_____

Business Address_____ Business Phone No._____

Name of Spouse_____ Spouse's Employer_____

Spouse's Date of Birth_____ Spouse's Social Security No. _____

How did you hear about us?_____

General Dentist - Name and Phone number_____

Person Responsible for Payment of Account_____

Address, if different from above_____

Dental Insurance Company_____

Medical Insurance Company_____

Spouse's Dental Insurance Company_____

Spouse's Medical Insurance Company_____

Medical History

Physician's Name_____ Phone:_____ Date of last physical:_____

Please check all that apply:

☐ Any heart problems
___Valve Replacement
___Pacemaker
___Angina
___A-Fibrillation
___Heart Surgery
___Heart Attack

☐ High blood pressure
☐ Low blood pressure
☐ Circulatory problems
☐ Stroke
☐ Anemia
☐ Bleeding Disorder/ excessive bleeding
☐ Cancer/Malignancies
☐ Radiation treatments
☐ Chemotherapy
☐ Osteoporosis

☐ HIV/AIDS
☐ Kidney Problems
☐ Thyroid Problems
☐ Liver Problems
☐ Hepatitis ___A__B__C
☐ Intestinal Problems
☐ Ulcers
☐ Reflux
☐ Eating disorder
☐ Alcohol consumption
How Much?_____
☐ Do you smoke?
How Much?_____
☐ Do you vape?
☐ Organ Transplant_____
☐ Diabetes/Hypoglycemia
☐ Seizure Disorder/Epilepsy
☐ Asthma
☐ COPD

☐ Tuberculosis
☐ Psychiatric care
☐ Sinus Problems
☐ Herpes/Shingles
☐ Venereal Disease
☐ Arthritis
☐ Joint replacement
Type:_____
☐ Osteoporosis
☐ Allergies to anesthetics
_____
☐ Allergies to medicines or drugs_____
☐ Other Allergies:_____
☐ Recovering from Addiction:
____Alcohol
_____Drugs

☐ Are you pregnant?
Due Date_____
☐ Blood Pressure :
S_____/D_____

☐ Have you traveled to: Liberia, Guinea or Sierra Leone in the last 21 days?

☐ If yes, when did you return to the US?_____

☐ Are you feeling feverish?

OTHER SIDE PLEASE!

List current medications and dose(including vitamins, herbal and over the counter):_____

_____

_____

_____

_____

Preferred Pharmacy (name, location & phone #)_____

List all hospitalizations:_____

_____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment._____

_____

Is there anything that you would like to discuss privately with the doctor?_____

_____

Patient Signature: _____ **Date**: _____

Doctors Signature:_____ **Date**:_____

OFFICE POLICY

We value you as a patient and strive to reserve appointment times that are convenient to your schedule. If you need to change the time that was reserved for you, please do so at least 48 business hours in advance. Surgical appointments not honored or changed with less than 48 business hours notice will be charged $300.00 and hygiene appointments will be charged the full provider fee for the scheduled service.

It is every patients' responsibility to provide correct dental benefit information. Towson Center for Dental Implants and Periodontics (TCDIP) will file insurance forms for you. By signing, patients covered under participating benefits plans authorize payments to be assigned to us, the providers of service. Payment of estimated co-payment is due at the time of service. Patients covered under non-participating benefit plans are expected to pay in full. Benefit reimbursements will be sent directly to patients.

Patients remain ultimately responsible for balances for services rendered. Patients must report changes to insurance information as soon as possible.

There will be a $35.00 returned check fee per item. Financing options are available in some instances. Patients using 3rd party financing must abide by terms set forth by the lender. Collection accounts will incur additional fees, court costs and attorney fees, if applicable. *If it becomes necessary to send my account to collection, I understand and agree that I will pay all collection costs, including but not limited to agency fees, court costs, the cost of a private process server if utilized, and reasonable attorney's fees.*

SIGNATURE: _____ Date:_____