DENTAL ASSOCIATES OF ROCKVILLE, LLC

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Welcome to Dental Associates of Rockville!

We thank you for making us your choice and joining with us in caring for your dental health. By becoming our patient, you have created a partnership which we hope will last through the years.

Since 1959, our partnership has been prevention orientated and dedicated to your health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long term dental health.

Our office hours are patient orientated. We are here as early as 7am, late as 7pm, and even on Saturdays. Because communication is important, we will advise you of treatment needs and expenses in advance, even assist with your insurance filing. We are here to serve you so please, do not hesitate to contact us regarding any matter.

We welcome new patients and appreciate any referrals we might earn. Our practice again welcomes you and looks forward to a long and healthy partnership with you, your family, and friends.

Best Regards,

Dental Associates of Rockville
David Janton DMD, Mang Shu DMD, and Sydney Spal DDS
Shannon, Sarah, Theresa, Carole, Janelle, Chelsea and Brianna

ADA American Dental Association®

America's leading advocate for oral health

Today's Date: ____________________

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	

If you are completing this form for another person, what is your name and relationship to that person? Name: ____________________ Relationship: ____________

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

- Is it hard to open your mouth? ☐
- Does it hurt to chew, bite or swallow? ☐
- Do your gums bleed when you brush or floss your teeth? ☐
- Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
- Do you have, or have you ever had, any sores or growths in your mouth? ☐
- Do you clench or grind your teeth? ☐
- Does your jaw click, pop or hurt? ☐
- Do you have earaches or neck pains? ☐
- Does dental treatment make you nervous? ☐
- Have you ever experienced any of these sleep-related breathing disorders? ☐
  ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

- Have you ever had a serious injury to your head or mouth? ☐
  If yes, please describe what happened and when it happened: ____________________
- Have you ever had problems with dental treatment in the past? ☐
  If yes, please describe what happened: ____________________
- Have you ever had a reaction to, or problem with, dental anesthesia? ☐
  If yes, please describe what happened: ____________________
- Are you unhappy with your smile?. ☐
  If yes, why? Please mark all that apply:
  ☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
  ☐ Other. Please describe: ____________________

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐

If yes, what medication are you taking? ____________________

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).

If yes, what medication are you taking? ____________________

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).

If yes, what medication are you taking? ____________________ How many years have you been taking it? ____________

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? ____________

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐

If yes, what substances? ____________ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? ____________

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐

If yes, please list them here and include information about how much and how often you use each one. ____________

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: ____________ ☐ ☐ ☐

Nursing? If yes, number of weeks: ____________ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:

	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: ______________________________

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: ____________			
Date of diagnosis: ____________			
Chemotherapy: ____________			
Radiation treatment: ____________			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____________			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐

	Yes	No	?
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: ____________			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. ______________________________

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5°F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: ______________________________ Date: ____________

FOR COMPLETION BY DENTIST

Comments: ______________________________

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: ______________________________ Date: ____________

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OFFICE AND FINANCIAL POLICY:

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, and Visa. Returned checks and account balances older than 90 days may be subject to additional collection fees. All collection costs, court costs, and attorney's fees will be your responsibility.

Charges may also be made for broken appointments. We must have 48 hours (2 days) notice of cancellation of appointments. If we do not have the required 48-hour cancellation notice, you may be charged a "No Show" fee of $50-150 (depending on service type). Patients that miss two or more appointments without calling to cancel/change their appointment will be discharged/dismissed from our practice. We currently have a waiting list of patients for appointments. If you cannot make your appointment, please notify us so we can give someone else that appointment time. Frequent missed appointments have a huge impact on our ability to see and treat our patients and cannot be overlooked.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered, as well as any costs incurred for collection.

______________________________________ ______________
Patient's signature Date

AUTHORIZATION TO PAY BENEFITS AND TO RELEASE INFORMATION

I hereby authorize payment directly to the above name dentist of the dental benefits otherwise payable to me. I hereby authorize the above-named dentist to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

______________________________________ ______________
Patient's signature Date

Dental Associates of Rockville, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

Signature__________________________________**Date**__________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT:

Name____

Address____

Telephone_________________________**Social Security #**__________________

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I,____________________________have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature______________________________________**Date**________________

Spouse/parent/Guardian_____________________________**Date:**___________

Notice of privacy practices

Important: this notice describes your privacy rights as a patient of Dental Associates of Rockville, LLC and how your medical information may be used and disclosed. Please review this notice carefully and let your service provider know if you have any questions.

Our Legal Duty

The terms of this notice of privacy practices applies to all services performed and are effective April 1, 2003. This organization and its employees will share individual patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This agency is required by law to maintain the privacy practices with respect to your individual health information. We reserve the right to change the terms of this notice of privacy practices as necessary.

Uses and Disclosures of Health Information

We may use or disclose health information about you for:

Treatment, Payment and Health Care Operations:

Except as otherwise provided, or with your signed consent, this agency will use your individual health information as necessary for purposes of your treatment, payment and as necessary for our health care operations which include clinical supervision, clinical improvement, professional peer review, business management, and accreditation and licensing, as permitted by law.

Family and Friends:

AUTHORIZATION IS NECESSARY TO RELEASE YOUR HEALTH INFORMATION

Business Associates

At times it may be necessary for us to provide your individual health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc.

Appointments and services

This agency may contact you to provide appointment reminders or information about your treatment alternatives or other health-related benefits and services that may be of interest to you.

Your rights

1. Access to individual health information

You have the right to inspect the record of your individual health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. We will charge you a fee of 25 cents per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information of you request such a summary.

2. Amendments to individual health information

You have the right to request in writing that individual health information that we maintain about you be amended or corrected.

3. Accounting for disclosures of individual health information

You have the right to receive an accounting of certain disclosures made by us of your individual health information after April 14, 2003.

4. Restrictions on use and disclosure of individual health information

You have the right to request certain restrictions on certain of our uses and disclosures of your individual health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests.

5. Complaints

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer at this practice. You may also file a complaint with the Secretary of the Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.