DENTAL FX
8667 Fort Smallwood Road
Pasadena, MD 21122
(410) 360-0440

Cancellation or no show without 48 hrs advance notice will result in a broken appt fee!

Patient Information

Patient Name: _____ Preferred/Nickname_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date:_____ Driver's License #_____

Address:_____

_____
City State Zip Code

Phone (Home): _____ (Work): _____ (Other/Cell)_____

Email Address:_____***We confirm our appts by email and/or cell phone. If you wish not to have this option, please let us know.***

Emergency contact?_____Phone _____Relationship_____

Date of Last Dental Visit:_____ Drs. Name:_____

Reason for Todays Visit?_____

Reason for Choosing New Dentist?_____

Type of water supply at home? Well_____City_____ At Work? Well_____City_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Anemia
☐ Arthritis
☐ Artificial Joints-Date placed_____
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes-Type____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ HIV / AIDS
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease/Stents
☐ Heart Murmur
☐ Hepatitis-Type_____
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ MRSA
☐ ORSA
☐ **Pregnancy** Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever-Date_____
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Codeine Allergy
☐ Penicillin/Amoxicillin Allergy
☐ Latex Allergy
☐ Sulfa Allergy
☐ List Any Other Drug Allergies

☐ ***LIST ANY MEDICATIONS (S) INCLUDING NON-PRESCRIPTION YOU ARE TAKING:***

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

How did you hear about us? ☐Another patient, friend ☐Commercial ☐ BriteSmile ☐ Merchanisder ☐ Insurance ☐ Yellow Pages ☐ Red Phone Book ☐ Placemat ad –List restaurant below ☐ Sign Other_____

Party Responsible For Payment

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Consent for Services

Payment is expected at time of service, unless other arrangements are made otherwise. In the event that an account must go to collections, patient will be responsible for all costs of collection, including but not limited to attorney fees. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Patients who do not show up on time for an appointment, or cancel with less than 48 hours notice will be charged a $60.00 fee per each 30 minutes. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

You will need to request in writing, and pay a reasonable copying fee (currently $25) if your want to have copies of your x-rays made or your records sent to another doctor or organization. Your authorize us to include all relevant information, including your payment history.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

A service charge will be imposed on each item of your account which has been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will computed at the rate of one and a half percent (1½%) per month or an ANNUAL PERCENTAGE RATE of eighteen percent (18% per annum). The finance charge on your account is computed by applying the rate (1½%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The mimimun finance charge is $.50.

You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. Any account that is turned over to a collection agency will be billed a process fee plus forty (40%) of the unpaid balance at the time of reporting to the credit bureau.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

DENTAL FX

Dr. Judy Yu
8667 Ft. Smallwood Road
Pasadena, Maryland 21122

Phone: (410) 360-0440
Fax: (410) 360-2359

Dear Patient:

In an effort to provide you with flexible payment arrangement, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options (PLEASE CHECK ALL THAT MAY APPLY):

_____ **Payment by cash**

_____ **Payment by check**

_____ **Payment by credit card (Visa, Mastercard, Discover, American Express)**

_____**Automatic billing to your Visa or Mastercard**

_____**Guarantee any amount not covered by insurance with Visa or Mastercard**

_____**CareCredit Patient Financing**

Please make your choice, sign below and return to the front desk coordinator before treatment.

Our office is fully approved and accredited user of the Visa and Mastercard health Care Program which will enable your to use your Visa and Mastercard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or Mastercard.

If none of the above apply, please see the front desk coordinator. Thank you.

_____
Print your name here and sign below

X_____ **Date**_____

Dr. Judy Yu
8667 Fort Smallwood Road
Pasadena, MD 21122
410-360-0440

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____