We would like to get to know you better!

65 Thomas Johnson Drive, Ste B
Frederick, MD 21702
Office (301) 698-0044

frontdesk@mvdental.net
www.monocacyvalleydental.com

Name: ______________________________ Nickname: _______________ ☐ Male ☐ Female

DOB: ____________ SSN: _______________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: ____

Home#: ______________ Cell#: _________________ Email: ______________________

How would you like us to contact you? ☐ Call ☐ Text ☐ E-mail

Please let us know how you found us? ☐ Google ☐ Facebook ☐ Insurance ☐ Patient* ☐ Other____________

**If one of our current patients referred you, please provide their name so they can receive their referral credit!* ______________

Emergency Contact: ______________________ Phone: ____________ Relationship: __________

Prior Dentist's Name: ______________________ How long since last hygiene visit: ____________

1. Dental Insurance: _________________ Employer: _________________ Group#:____________

Name of Insured: ________________________ DOB: ____________ SSN: ____________

Member ID #: _________________ Insured relationship to patient: ____________

2. Dental Insurance: _________________ Employer: _________________ Group #: ____________

Name of Insured: ________________________ DOB: ____________ SSN: ______________

Member ID #: _________________ Insured relationship to patient: ____________

PLEASE NOTE: *Social Security Numbers are required by dental insurance companies in order for our office to file dental insurance claims on the patient's behalf. Failure to provide this information will result in payment due at time of service.*

Complete page 2 on reverse side

Patient Medical History

Conditions	Yes	No	Conditions	Yes	No	Conditions	Yes	No
Abnormal Bleeding			Emphysema			Mitral Valve Prolapse		
AIDS/HIV Positive			Epilepsy			Pace Maker		
Alcohol Abuse			Fainting Spells			Radiation Therapy		
Allergies			Fever Blisters			Rheumatism		
Anemia			Hay Fever			Respiratory Disorders		
Arthritis			Hearing Impaired			Seizures		
Artificial Heart Valve			Heart Attack			Shingles		
Asthma			Heart Surgery			Sinus Problems		
Blood Disease			Heart Valve, Murmur			Stroke		
Cancer			Headaches/Migraines			Thyroid Problems		
Chemotherapy			Hepatitis ______			Tuberculosis		
Colitis			High Blood Pressure			Ulcers		
Congenital Heart Defect			Hip/Joint Replacement					
Dental Anxiety			HPV					
Depression/Anxiety			Kidney Problems			**ALLERGIES:**		
Diabetes			Liver Disease			Aspirin		
Drug Abuse			Low Blood Pressure			Codeine		
						Jewelry		
						Latex		
						Metals		
			Do you smoke or chew tobacco?			Penicillin		
						Tetracycline		
						Sulfa		
						Epinephrine		
						________________Other		

Are you taking, or have you ever taken bisphosphonates such as Fosamax or Actonel? YES NO

List any medications you are taking, including nonprescription drugs:	FOR WOMEN ONLY:
	Are you taking birth control pills? **Yes** **No** Are you pregnant? Possibly? **Yes** **No** Are you nursing/breastfeeding? **Yes** **No** *Note: Antibiotics may alter the effect of birth control pills.*

Is there any disease, condition, problem or recent surgery that you think this office should know about that is not covered above? YES NO If yes, please explain.

Primary Care Physician: Phone:

Signature: ____ Date: ______________

(If Under 18 years old, Parent or Guardian Signature Required)

FINANCIAL AGREEMENT

For your convenience we offer several options of payment: cash, check, debit or credit card. We also have companies willing to finance dental treatment with no money down. These payment options can be discussed further with our Billing Coordinator and payment arrangements must be agreed upon before treatment is initiated.

Each patient will receive an estimate for treatment needed, which will include their co-pays and deductibles. This is only an estimate and you are responsible for amounts not paid by insurance. We cannot guarantee what insurance will or will not pay. You are responsible for your account. All estimated payments are due at time of service.

If you have dental insurance, we will gladly file your claim for you; if you have secondary dental insurance, we will also file these claims for you as a courtesy. If your insurance neglects to submit payment within 60 days from your date of service, the balance on the account becomes your responsibility. If your account becomes delinquent, it will be turned over to a collection agency and you will incur any collection costs and any related attorney's fees. If a check payment is returned to us by the bank, you will be responsible for any bank fees we incur as a result of that returned check.

We reserve the right to charge $50.00 per hour for all broken/cancelled appointments that do not allow 24-hour notice *(Monday appointments must be cancelled by Friday at 12pm)*. In addition, if a patient breaks or cancels an appointment without at least 24-hour notice for any extensive treatment, you may be expected to pay a deposit for future appointments at time of scheduling.

As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care to you, your family and friends.

____ ____________________
Patient Name *Relationship to Patient*

____ ____________________
Signature *Date*

Updated October 3, 2018

HIPAA ACKNOWLEDGEMENT AND RELEASE

I hereby authorize Brian K. Motz, DDS PC *dba Monocacy Valley Dental (MVD)* to use and disclose my protected health information (PHI) to carry out payment activities in addition to treatment and health care operations. I have the right to read the Notice of Privacy Practices prior to signing this consent. I may obtain a copy of this notice by contacting the office. MVD reserves the right to revise its Notice of Privacy Practices at any time. I have the right to restrict how MVD uses or discloses my PHI for treatment, payment or health care operations. Whenever possible, MVD will honor my request. I also have the right to revoke this consent at any time, in writing, but such revocation will not affect any disclosures already made.

____ ____________________
Patient Name *Relationship to Patient*

____ ____________________
Signature *Date*

I authorize the release of my protected health information to:

**This Release of Information will remain in effect until terminated by me in writing.*

☐ Spouse: ____

☐ Child(ren): ____

☐ Other: ____

____ ____________________
Patient Name *Relationship to Patient*

____ ____________________
Signature *Date*

Updated October 3, 2018