MONOCACY VALLEY DENTAL

161 Thomas Johnson Drive, Ste 195 Frederick, MD 21702 Office (301) 698-0044

We would like to get to know you better!

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.*_____

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.

MONOCACY VALLEY DENTAL
BRIAN MOTZ, DDS

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)

MONOCACY
VALLEY
DENTAL

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 January 19, 2021

MONOCACY
VALLEY DENTAL
BRIAN MOTZ, DDS

Financial Policy and Insurance Addendum

MVD Financial Procedures

We are pleased to welcome you to our practice. The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient, and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made. We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visit's total bill. Please bring cash, check or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

Please be aware, we only honor our treatment fees for 90 days.

In fairness to our patients and staff we have implemented a cancellation/payment policy as follows:

Outstanding balances on your account are discouraged and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement. Delinquent balances over 90 days old will be referred to collections.

All referred accounts are marked "Inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance plus a "Reactivation Fee" of 50% of the delinquent balance referred to the collection agency will be charged to your account. Only after this total account balance has been paid in full can appointments be made and your account and patient status be reactivated. A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or by VISA, MasterCard, AMEX, Discover or CareCredit.

Your dental appointments are scheduled carefully. Time, trained personnel, and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 48 hours advance notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $50.00 for repeatedly missed appointments without proper notification.

Dental Claims Submission Policy

Every insurance company call begins with a disclaimer that the information given is not a guarantee of coverage; this protects them from being held liable for an inaccurate quote. While we work diligently to provide accurate insurance coverage, it is possible to be misquoted over the phone based on several potential errors. We can only provide an estimate and the subsequent contracted amount is based on that information. Insurance companies are required by law to forward a full explanation of benefits to their subscribers once a claim is submitted. Benefits are an estimate and not a guarantee of a payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

As a courtesy, our office submits claims to your insurance companies(s) and the expected benefits are credited to your account ledger. and do everything possible to obtain the maximum coverage to which you are entitled. Since dual insurance plans follow various coordination of benefits standards, our office will only accept the assignment of benefits for your primary insurance plan. We will submit claims to primary and secondary insurance companies as a courtesy, however; the secondary plan benefits will be paid to the subscriber directly. In order to simplify this process, we must have a current copy of your insurance card along with the primary insured name, date of birth and social security number. Without this information we are not able to bill your insurance.

In certain circumstances, we do collect payment prior to the date of service. Particularly, this is for patients that choose to have sedation. We will never collect money from a sedated patient therefor, their services must be paid prior to their appointment.

*We do not bill Medicare or any medical insurance companies

**Our financial agreement states that any shortfall from the expected insurance benefit is ultimately the account holder's responsibility.*

Thank you for taking time to read and understand our Payment Policy. Please let us know if you have any questions before signing below.

I hereby state that I have read and understand this financial policy and agree to the terms of this policy.

X_____ **Date**_____

Signature of patient or responsible party