Owings Mills Dentistry: Ai Vo, DDS

10995 Owings Mills Boulevard, Suite 218 // Owings Mills, MD 21117

Date: _____

Patient Information

Patient's Name: _____ Sex: M / F

Birth Date: _____ Marital Status: Single Married Separated Divorced Widowed

Patient's Address: _____

City/State/Zip: _____ Drivers License #: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: _____ Social Security #: _____

Please indicate who referred you to our office:

_____Direct Mailer _____ Our Website _____ Internet

_____ Insurance website Person (name) / Other: _____

Employer Information

Employer: _____ Occupation: _____

Employer's Address: _____

City/State/Zip: _____ Phone #: _____

Spouse/Guardian Information

Spouse/Guardian Name: _____ Relation to Patient: _____

Spouse/Guardian Social Security #: _____ Primary Phone #: _____

Spouse/Guardian Employer: _____ Occupation: _____

Spouse/Guardian Employer Address: _____

Spouse/Guardian DOB: _____ City/State/Zip: _____

Emergency Contact - Please provide the Name, Address and Phone #

_____

Billing Information

Please indicate the person financially responsible for this account (if other than patient)

Name: _____ Relation to Patient: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____ Social Security #: _____

Employer: _____ Financial Institution: _____

Patient Name:_____

Medical History

Please indicate any health conditions you have or have had:

_____

_____

_____

Name of Physician: _____ Phone #: _____

List **ANY** medications, including non-prescription drugs or herbal supplements you take:

_____

_____

Please circle any of the conditions that apply to you:

Heart Disease	Artificial Heart Valve	Liver Disease	Tuberculosis
Heart Attack	Stroke	Hepatitis	Venereal Disease
Angina (chest pains)	Bleeding Disorder	Ulcers	Bruise Easily
Heart Murmur	Anemia	Epilepsy	Diabetes
Heart Defect	Hemophilia	Seizures	Thyroid Disease
Heart Surgery	Artificial Joints	Drug Addiction	Allergies
Heart Pacemaker	AIDS / HIV	Alcoholism	Frequent Cough
Heart Failure	Psychiatric Treatment	Cancer	Sinus Trouble
High Blood Pressure	Blood Transfusion	Emphysema	Arthritis
High Cholesterol	Kidney Problems	Asthma	Steroid Treatment

Do you take antibiotics prior to Dental Treatment? If so, please list: _____

Are you allergic of have you had any bad reactions to the following?

Aspirin (Nsaids, Motrin, etc.): _____

Local Anesthetics: _____

Codeine or Other Narcotics: _____

Sensitivity to Metal: _____

Latex Allergy: _____

Antibiotics (please specifiy): _____

Other (please specifiy): _____

Are you pregnant? Possibly pregnant? Do you take birth control pills? _____

Other important medical information: _____

Patient's Signature (guardian, if minor): _____ (SEAL) Date: _____

Doctor's Signature: _____ (SEAL) Date: _____

Patient Name:_____

Dental History

When was your last *complete* dental exam? _____

When did you last have a full X-Ray series or Panorex? _____

Please circle any of the following dental concerns you may have:

☐ Aesthetics / Appearance	☐ Toothaches	☐ Loose Teeth
☐ Headaches	☐ Discoloration	☐ Bleeding Gums
☐ Grinding	☐ Tooth Replacements	☐ Oral Ulcerations
☐ Sensitivity	☐ Fit of Dentures	☐ Herpes / Cold Sores

Are you currently experiencing any dental problems? _____

_____

Name of previous dentist: _____ Phone #: _____

Insurance Information

Name of Insured: _____

Social Security #: _____ Employer: _____

Insurance Company Name and Address: _____

_____

Secondary Insurance Information (if applicable)

Name of Insured: _____

Social Security #: _____ Employer: _____

Insurance Company Name and Address: _____

_____

Dental Insurance is a contract between the insurance carrier and the insured, NOT the dentist. The patient / responsible person is liable for all dental fees. Insurance benefit estimates are only guidelines until insurance carrier has paid.

Patient Name:_____

Consent

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, medical and dental records, and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I hereby authorize Stuart M. Brown, DDS, PA t/a Owings Mills Dentistry to speak with any health care practitioner who has treated or is currently treating me and/or my dependent(s) about my past or present medical or dental diagnosis, condition, or treatment. This authorization includes the release of my dental or medical records to Stuart M. Brown, DDS, PA t/a Owings Mills Dentistry as the practice deems necessary and remains valid until revoked, in writing. I authorize Stuart M. Brown, DDS, PA t/a Owings Mills Dentistry to perform all recommended treatment and therapeutic procedures to include administering medication as prescribed by the practice and mutually agreed upon by me. I accept the financial agreement outlined below, as well.

Financial Agreement

I agree to be responsible for payment of all services rendered on the behalf of my dependents and of myself. I agree that any claims the insurance carrier does not pay within thirty (30) days from the date of treatment are my responsibility to pay and that a finance charge of 1.5% per month may be assessed. I assign all dental benefits to which I am entitles under my insurance plan (if any) to Stuart M. Brown, DDS, PA t/a Owings Mills Dentistry. I also authorize this office to submit insurance claim forms and receive payment directly from the insurance carrier with the notation, "SIGNATURE ON FILE". I authorize Stuart M. Brown, DDS, PA t/a Owings Mills Dentistry to release treatment records, x-rays, and any other information deemed necessary and requested by my insurance carrier. I agree to pay reasonable collection fees and/or attorney's fees and court costs that may be incurred if such services are required by Stuart M. Brown, DDS, PA t/a Owings Mills Dentistry to collect any balance that I owe.

I understand and agree that I may be charged for repeatedly breaking or missing appointments without notifying the office at least 24 hours in advance, at the rate of *$155 per hour* to cover the operating expenses of the office. This fee is not covered by any insurance plan.

Preferred payment method:

_____ Payment in full by cash or check

_____ Payment in full by major credit card (see agreement)

_____ Insurance co-payment in full at time of visit

_____ Prearranged financial agreement made with office

Patient's Signature (guardian, if minor): _____ (SEAL) Date: _____

Printed Name: _____ (SEAL) Date: _____

Spouse's Signature: _____ (SEAL) Date: _____

Printed Name: _____ (SEAL) Date: _____

Doctor's Signature: _____ (SEAL) Date: _____