BOENNING & DANCYKIER
DENTAL IMPLANTS & COSMETIC DENTISTRY
of Towson

Date: _____

Patient Name: _____ Date of Birth: _____

[ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. [ ] Dr. **Email**: _____

Home Address:_____City:_____

State: _____ Zip code: _____

Phone Numbers:

Home: _____ Cell: _____ Work: _____

[ ] Male [ ] Female [ ] Other Marital Status: _____ Social Security # _____

***Please present your Identification for your patient record.**

Employer Name: _____ Occupation: _____

Person responsible for the account is [ ] Self [ ] Spouse [ ] Other _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Insurance Information:

Subscriber Name:_____ Relationship to the Patient:_____

Subscriber Date of Birth:_____

Address if different from the patient:_____

Insurance company:_____ Claims Phone # _____

Claims Address:_____

Subscriber ID:_____ Group #_____

Whom may we thank for referring you? _____

Reason for today's visit: _____

Date of last dental visit:_____

Check [√] if you have been diagnosed with or had problems with any of the following:

__Bad breath
__Loose teeth or broken fillings
__Sensitivity when biting
__Teeth grinding
__Sensitivity to sweets
__food collection between teeth
__Sensitivity to hot
__Clicking or popping jaw
__Sensitivity to cold
__Bleeding Gums
__Cold sores/fever blisters/herpes
__ Bulimia
__Dental Infections
__Periodontal Disease
__Loose Implant
__TMJ Disorder
__ Missing Crowns

How would you rate your dental current health? __ Excellent __Good __Fair __Poor

How often do you floss? _____ How often do you brush? _____ What type of toothbrush do you use? _____

Would you be interested in purchasing an electronic toothbrush? __Yes __No

Would you like straighter teeth? __Yes __No Whiter teeth __Yes __No Reducing snoring? __Yes __No

Personal Health

Although in Dentistry we primarily treat the mouth and all its structures, the oral cavity is connected to the rest of the body and acts as the gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Therefore, it is important that you answer all the pertinent questions. Thank you.

Do you Premedicate with antibiotic prior to dental treatment? __ No __Yes (if Yes Why?)

_____

Name and phone of your current physician: _____

Date of your last physical exam: _____

Medications/Supplements: Please list all prescription and non-prescription medications, injections, infusions, vitamins, home remedies, herbs, and topical creams:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies, adverse reactions or sensitivities to medications or food? (if yes please list) __Yes __No

_____

Please list all operations/hospitalizations with approximate dates that occurred within 10 years:

_____ _____ _____

_____ _____ _____

Check [√] if you have ever been **diagnosed or treated** for any of these medical conditions or problem:

__Periodontal Disease
__ Anemia
__ Gallbladder Problems
__ Bacterial Endocarditis
__ High Red Blood Cell Count
__ Pancreatic Disease
__ Pacemaker
__ Leukemia
__ Lupus
__ Heart Disease
__ Abnormal Platelet Count
__ Hepatitis Type__
__ Stroke
__ Stomach Ulcers
__ Gout
__ High Cholesterol
__ GERD/Chronic Heartburn
__ Sjogren's Syndrome
__ Lymes Disease

__ High Blood Pressure
__ PTSD
__ Auto Immune disorder
__ Pre-Diabetes
__ STD
__ Thyroid Problems
__ Diabetes
__ Epilepsy/Seizures
__ Depression
__ Mini Stroke of TIA's
__ Cancer
__ Anxiety/Panic Attacks
__ Atrial Fibrillation
__ Artificial Heart Valve
__ Migraine headaches
__ Poor Blood flow
__ Asthma
__Tuberculosis
__ Colitis

__ Heart Arrhythmia
__Osteopenia/Osteoporosis
__ Fibromyalgia
__ Heart Valve Problem
__ Blood Clots(arms,legs,lungs)
__ Emphysema/COPD
__ Rheumatoid Arthritis
__ Alcoholism
__ Bleeding/clotting problem
__ Kidney Disease
__ Drug use/addiction
__ Blood Transfusion
__ Kidney Stones
__ Mental Disability
__Sleep Disorder/Apnea
__ Joint Replacement
__ HIV/AIDS
__ Parkinsons
__ Congestive Heart Failure

__ Other Explain:_____

Use Tobacco or Marijuana? __Yes, how Long_____ how much_____ __Never __Quit, when_____

What Kind: __Cigarettes __Pipe __Cigar __Chewing tobacco __E-Cigarettes __Vape __Marijuana

Are you interested in quitting? __Yes __No Have you tried to quit in the past? __Yes __No

How many times have you tried to quit? _____ What methods have you tried? _____

Are you exposed to second-hand smoke? __Yes __No If yes, for how long? _____

Do you drink alcohol? __Yes __No

If yes, how many drinks do you consume per week? _____Alcohol type? _____

Does your alcohol consumption have you or others concerned? __Yes __No

Please tell us your preferred Pharmacy: _____

Address_____ Phone:_____

I give permission for the office of Boenning and Dancykier to use electronic databases to access and send my prescriptions and information. __Yes __No
(Please note that that by choosing no to electronic services you may not be able to get prescriptions from us.)

Signature: _____ Date: _____

Consent for Services and FinancialPolicy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will submit patient's insurance forms as a courtesy.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment. I further agree to pay all costs incurred by a collection agency or any possible attorney's fees and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize Boenning & Dancykier to release my personal/dental information to the following individual(s):

Please enter name and relationship to patient.
(Ex. Parent, sibling, caretaker, doctor, or someone else you trust who needs to know)

_____

*By signing below, I understand the above information and agree with its contents, and this will serve as my signature for the HIPAA Disclosure Form and Consent for Services and Financial Policy.

NAME: _____ **DATE**: _____

BOENNING & DANCYKIER
DENTAL IMPLANTS &
COSMETIC DENTISTRY
of Towson

1104 KENILWORTH DRIVE, SUITE 104
TOWSON, MARYLAND 21204

DIRECTIONS:

From the East (White Marsh) on 695, take Charles Street Exit 25.

Turn left at the top of the exit ramp traffic light, turn left onto Charles Street. At the 2nd traffic light, turn left onto Kenilworth Drive. Make the first left at the sign 1122 – The Exchange, go down the hill to 1104 – The Charles Towson Bldg. (white bldg.). We are located on the ground floor at the right front corner of the building, Suite # 104.

From the West (Pikesville) or 83, take the Charles Street Exit 25.

The ramp puts you on Charles Street (bear right at the ramp light). Turn left at the next traffic light onto Kenilworth Drive. Make the 1st left at the sign 1122 – The Exchange, go down the hill to 1104 – The Charles Towson Bldg. (white bldg.). We are located on the ground floor at the right front corner of the building, Suite # 104.