



In our efforts to save paper, we keep all of our patient's files electronically. With this in mind, please do not print these forms out. If you are unable to fill it out online and e-mail it back to us, we can have you fill it out on our office computer. Thank you for helping us on our mission to become more environmentally conscious.

Patient Information (Confidential)

Name:

Date of Birth:

Address:

Marital Status:

Gender:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Person to Contact in Case of Emergency:

Contact Info:

Patient's or Parent's Employer:

Business Address:

If Patient is a Student, Name of School/ College:

Whom May We Thank for Referring You?

Responsible Party

Name of Person Responsible for this Account:

Relationship to Patient:

Date of Birth:

Address:

Home Phone:

Employer:

Work Phone:

Is this Person Currently a Patient in our Office?

Insurance Information

Primary Insurance

Name of Insured:

Relationship to Patient:

Date of Birth:

Name of Employer:

Insurance Company:

ID No. / Social Security No.:

Group No.:

Ins. Phone No.:

Secondary Insurance

Name of Insured:

Relationship to Patient:

Date of Birth:

Name of Employer:

Insurance Company:

ID No. / Social Security No.:

Group No.:

Ins. Phone No.

Patient Medical History

Physician Name:

Office Phone:

Date of Last Exam:

(Double-click box to check, or replace w/ X) Yes No

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any serious surgical operation or illness? Yes No
3. Are you taking any medications including non-prescription medicine? Please list: Yes No
4. Do you use tobacco? Yes No
5. Do you use alcohol, cocaine or other drugs? Yes No
6. Are you wearing contact lenses? Yes No

7. Are you allergic to or have you had any reactions to the following?

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| Local Anesthetics (eg. novacaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |

8. Women Only:

- | | | |
|-------------------------------------|--------------------------|--------------------------|
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you ever had any of the following?

- | | Yes | No | | Yes | No | | Yes | No |
|------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement / Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS of HIV | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Other (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Patient Dental History

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing/flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever has instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficult in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release the diagnosis and the records of any examination rendered during the period of such Dental care to third party payors and/or health practitioner

Patient's/account holder Signature:

Date:

(To be signed electronically in the office.)

P O T O M A C
D E N T A L C E N T E R

11404 Old Georgetown Road Suite 201
Rockville, MD 20852
Ph: (301) 881-5020
Fax: (301) 881-5030

5247 Wisconsin Ave, N.W. Suite 3A
Washington, D.C. 20015
Ph: (202) 362-7418
Fax: (202) 362-7410

Financial Policy

Basic Policy: Payments for services rendered is due in full at time of Service. Our office accepts checks, cash and credit cards.

PATIENTS WITH INSURANCE: As a service to our patient, we will bill your insurance carrier, provided proper insurance information is given to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made so closely estimate your co-payments and deductibles which are due at time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

Non-covered charges: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least **24 hour's** notice when canceling an appointment. There is a **\$50/hour** fee for missed appointments without 24 hour notification, which all be due payable from you. Payments Plans are available and arrangements must be made in *advance* of treatments. **Account Balances are Due Upon a Receipt of Statement from our Office.** Any charges incurred by this office related to collection of overdue accounts will be added to the patients account.

A fee of **\$35** will be charged for any returned checks.

I hereby assign all dental and/or surgical benefits, private insurance, and other health plans, to **ELENIR BERNARDES D.D.S.** This assignment will remain in effect until revoke by me writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read and understood and agree to the above financial policy for payment of professional fees. I understand that **I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICE PROVIDED TO ME.**

(To be signed electronically in the office.)

Patient's/account holder Signature:

Date:

DR. ELENIR BERNARDES, DDS
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:

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

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