Welcome to our office….

**Howard A. Katz, D.D.S., P.A. & Associates** 2705 Mountain Rd., Pasadena, MD 21122

Date _____ Home Phone _____
Cell Phone _____
Work Phone _____

# CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____
Last First Middle Initial
Address _____
City _____ State _____ Zip _____
M __ F __ Birthdate _____ Weight _____ Single__ Married __Divorced __Separated __Widowed __
Email Address _____ Employer _____Occupation _____
Person to call if unable to reach you _____ Phone # _____
Relationship _____ Patient referred by _____

## WHO IS RESPONSIBLE FOR PATIENT'S DENTAL EXPENSES?

Relationship to patient: Parent _____ Spouse _____ Self _____ Other _____
Name: _____ Date of birth _____ Social Security # _____
Address (if different than patient's) _____
Employer _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email address _____

## PRIMARY DENTAL INSURANCE

Subscriber Name _____ DOB _____ SS # _____
Address (if different than patient's) _____
Employer _____Employer Phone # _____
Employer Address _____
Name of Dental Insurance Co. _____ Ins. Co. Phone # _____
Relationship to Patient _____ Policy ID # _____

## SECONDARY DENTAL INSURANCE

Subscriber Name _____ DOB _____ SS # _____
Address (if different than patient's) _____
Employer _____Employer Phone # _____
Employer Address _____
Name of Dental Insurance Co. _____ Ins. Co. Phone # _____
Relationship to Patient _____ Policy ID # _____

## RESPONSIBLE PARTY CONSENT

I have completed the questionnaire and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health, insurance, or contact information. I understand and agree that I am completely responsible for payment regardless of my insurance coverage at the time services are rendered. If it becomes necessary to send my account to collections, I understand and agree that I will pay all reasonable fees related to collections, including but not limited to lawyer's fees of 35 %, court costs and the costs of a private process server to the amount owed.
Any unpaid balance will be subject to interest at a rate of 1.5% monthly.

Responsible Party Signature Relationship to patient Date

**********Please Complete the Other Side of this Page!**********

## DENTAL HISTORY

Date of Last Dental Visit _____ X-Rays Taken? ☐ Yes ☐ No
Name of Your Last Dentist _____ Phone _____
Please check all that apply:

☐ Bleeding Gums ☐ Sensitivity ☐ Grinding Teeth
☐ Sore Gums ☐ Swelling in the Mouth ☐ Ulcers of Cold Sores
☐ Loose Teeth ☐ Clicking or Popping Jaw ☐ Pain

## MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____
Are you under the care of a physician at this time? ☐ Yes ☐ No

(women only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Have you ever been sedated for any surgery? ☐Yes ☐ No
Any Difficulty? ☐ Yes ☐ No

## MEDICATIONS

List any Medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone _____

## ALLERGIES

☐ Aspirin
☐ Codeine
☐ Penicillin
☐ Sulfa
☐ Other _____

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Have you ever had any of the following? (Check boxes that apply)

☐ Addictive Disorder ☐ Epilepsy ☐ Mitral Valve Prolapse
☐ Allergies ☐ Facial Trauma ☐ Nervous Problems
☐ Anemia ☐ Fainting ☐ Persistent Fever
☐ Arthritis ☐ Heart Attack ☐ Respiratory Disease
☐ Artificial Heart Valve ☐ Heart Murmur ☐ Rheumatic Fever
☐ Artificial Joints ☐ Heart Surgery ☐ Scarlet Fever
☐ Asthma ☐ Hemophilia ☐ Shortness of Breath
☐ Cancer ☐ Hepatitis ☐ Sinus Problems
☐ Circulatory Problems ☐ High Blood Pressure ☐ Stroke
☐ Congenital Heart Disease ☐ HIV Positive ☐ Tobacco Habit
☐ Diabetes ☐ Kidney Disease ☐ Tuberculosis
☐ Emphysema ☐ Low Blood Pressure ☐ Venereal Disease

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Please Read and Sign

## YOUR DENTAL INSURANCE

It is our goal to not only provide you with the highest quality dental care at reasonable prices, but also to make you aware of all fees before treatment has begun, when possible. Our staff is here to help you by submitting all forms to your dental insurance company and do everything possible to give you an accurate estimate of the "out of pocket" expense to you based on your plan benefits.

PRIOR TO TREATMENT WE WILL:

1. Give a detailed outline of your insurance benefits, as quoted by the insurance company.

2. Submit a detailed and accurate claim so that the maximum benefit can be paid on your behalf.

3. Provide you with your estimated fee based on what your plan does and does not cover.

4. Submit for a pre-approval for any crowns bridges dentures, etc.

Please understand that we do everything possible to make this estimate accurate. The insurance company ultimately has the responsibility for paying the claim and WILL adjust the payment depending on eligibility when services are rendered, plan maximums, and plan deductibles, etc., which may cause our estimate to differ from your actual cost.

YOUR RESPONSIBILITIES:

1. Provide our staff with any current information you may have regarding your dental insurance coverage.

2. Provide a dental claim form and insurance card, when applicable.

3. Make arrangements to pay the "out of pocket" expense on the day treatment is performed.

PLEASE NOTE: This is your dental insurance. Our office has no control over what your insurance ultimately pays. If you have any questions regarding your plan, amounts not covered by your insurance, or benefits please contact your insurance representative or your personnel office at your place of employment.
We look forward to serving you. Please feel free to ask any questions that you may have.

Signed _____ Date _____

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# CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

To the Patient- Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment payment activities and health care operations, and the use and disclosures we may make of your protected health information. A copy of this Notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes.

Right to revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. We are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

PATIENT GIVING CONSENT

Name (please print) _____

Address _____

_____

Phone _____

Social Security # _____

I, _____ have had the opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent t your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature of Patient (or patient's representative) _____
Patient representative's relationship _____