THE BARLOW BUILDING
5454 Wisconsin Avenue, Suite 1350
Chevy Chase, MD 20815
Phone: *(301)652-1545* ***Fax:*** *(301)652-4171*

Patient Information

Name: ______________________________________ Last Name: ____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Partner ○ Divorced ○ Separated ○ Widowed

Date of Birth: ______________________________ Social Security#:____

Address: ____

City, State, Zip: ____

Home Phone:______________________ Work Phone: ____________________ Cell Phone:_______________________________________

E-mail:____ Employer: ____

Employer Address:________________________________ City, State, Zip: ____

Physician:________________________________Phone:__________________Dentist:____________________Phone:___________________

Primary Insurance Information

Name of Insured: __________________________________Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Employer : ____

Employer Address:____ City, State, Zip:____

Ins. Company:____ Ins. Address:____

Carrier ID:________________ Group#:_________________ Soc. Sec.#:________________ Date of Birth:____________________

Secondary Insurance Information

Name of Insured:__________________________________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Employer : ____

Employer Address:____ City, State, Zip:____

Ins. Company:____ Ins. Address:____

Carrier ID:________________ Group#:_________________ Soc. Sec.#:________________ Date of Birth:____________________

*Who may we thank for your referral?*____

____

Signature of Patient or Guardian ***Date***

Bethesda Chevy Chase
ADVANCED DENTISTRY
George Gotsiridze DMD

PATIENT MEDICAL HISTORY

Patient Name: ____Date of Birth:_________________________________

Although dental practitioner primarily treat the area in and around your mouth, the mouth is a part of your entire body. Health problems that you may have, of medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Has there been any change to your general health with the past year? ○ Yes ○ No
If yes please describe: ____

Have you ever had any serious illnesses, operations or hospitalizations? ○ Yes ○ No
If yes please describe: ____

Are you taking any medications or pills? ○ Yes ○ No *If yes please describe*: _________________________
____

Are you under a physician's care now? ○ Yes ○ No *If yes please describe* _________________________
Do you take or have you taken bisphosphonates? ?○ Yes ○ No
Do you use tobacco? ○ Yes ○ No Do you use a controlled substances? ○ Yes ○ No
Are you on a special diet? ○ Yes ○ No
Have you ever been diagnosed with sleep apnea? ○ Yes ○ No Do you use any type of appliance? _________
Women: **Are you ☐ Pregnant/Trying to get pregnant ☐ Nursing? ☐ Taking birth control pills**

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other
____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Shingles
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sinus Trouble
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Spina Bifida
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Stomach Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stroke
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Pain in Jaw Joints	☐ Swelling Limbs
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Radiation Treatments	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Renal Dialysis	☐ Ulcers
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatism	☐ Yellow Jaundice*
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Scarlet Fever*	*may need premedication

Do you have a family history of Diabetes _____Heart Disease ______Periodontal Disease______

To the Best of my knowledge, the questions on this form have been accurately answered. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my (the patient's) health.
It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any all information necessary to secure the payment and understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

Signature of Patient or Guardian ***Date***

Bethesda Chevy Chase
ADVANCED DENTISTRY
George Gotsiridze DMD

Dental Information

Our office is like no other dental office. Your first visit will be one of the most important dental visits you will ever have since we place a strong emphasis on helping you determine your present and future dental needs. Here are some of the things we are going to be discussing with you, some of which you may never consider.

Reason for today's Visit: Exam ○ Yes ○ No   Emergency ○ Yes ○ No   Consultation ○ Yes ○ No
Are you in pain? ○ Yes ○ No   *If yes describe*____

Last Dental Exam: _________________________________   Last Dental X- Rays: ____

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

☐ Gums that bleed, are tender, swollen or irritated
☐ Sensitive teeth (heat, cold, sweets, pressure)
☐ Food wedging between teeth
☐ Artificial replacement for missing teeth
☐ Grinding or clenching of teeth
☐ Burning of tongue and mouth
☐ Endodontic therapy (root canal)
☐ Offensive breath
☐ Bad taste
☐ Periodontal therapy (gum treatment)
☐ Injury to jaw or mouth
☐ Swellings, lumps, or white patches in your mouth
☐ Popping, clicking or snapping noises
☐ Nasal Obstruction
☐ Ulcers or fever blisters
☐ Allergy to local anesthesia
☐ Orthodontic therapy
☐ Frequent headaches or neck aches
☐ Extractions
☐ Professional home care
☐ Equilibration (grinding. Bruxing)
☐Recent weight loss or gain

Do you require pre medication? ○ Yes ○ No   *If yes describe*____

Is there any additional information you would like us to know? ____

Preferred Method of Appointment Confirmation

This system must be utilized due to the new care act. Please check all that apply.

Name: ______________________________

Date: ______________________________

○ Email: ____________________________

○ Text: _____________________________

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PATIENT FINANCIAL TERMS & CONDTIONS

ALL DENTAL SERCIVES ARE THE PATIENT'S RESPONSIBILTY REGARDLESS OF INSURANCE COVERAGE OUR OFFICE WILL BILL YOUR INSURANCE COMPANY ONE (1) TIME ONLY BASED ON THE INFORMATION YOU PROVIDE TO THE OFFICE. ALL ACCOUNTS ARE COMPUTER GENERATED AND TURNED OVER TO A BILLING AGENCY AFTER ONE (1) CYCLE. ANY ACCOUNT THAT IS NOT PAID IN FULL WITHIN THE SIXTY (60) DAY GRACE PERIOD WILL AUTOMATICALLY BE SENT TO COLLECTIONS, UNLESS OTHER SPECIFIC ARRANGEMENTS ARE DISCUSSED.

We are committed to providing you with the best possible dental care and service. If you have dental insurance, we are happy to assist you to receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. Despite having dental insurance, it is ultimately your responsibility to pay the provider for the services rendered and to assure that your insurance company properly processes your claim and pays your provider.
We require a minimum notice of ***48 hours*** *for any appointment changes. A fee of* ***$75.00*** *will be applied to your account for broken or cancelled appointments without* ***48 hour advance notice****. This fee must be paid prior to any future treatment.*

Financial Policy

We will gladly discuss your proposed treatment and charges and will answer any questions. In our efforts to keep dental costs at a minimum while maintaining a high level of professional care, we have established the financial policies:

1. **Patients without Participating Insurance Coverage:**
   Payment is expected at the time of visit. We accept cash, checks, MasterCard, Visa, Discover and American Express. *We will be happy to process your insurance claim form for your reimbursement.*
2. **Patients with Participating Insurance Coverage:**
   We will file your insurance for you providing we have been able to obtain verification of eligibility prior to your scheduled appointment.
   Deductibles and estimated patient portions will be collected at the time services are rendered.
   ALL fees related to any and all treatment are the full responsibility of the patient. In the event that payment is not received within 35 days from treatment date from your insurance carrier; **OR** the amount paid is different from the estimated portion, the **remaining balance** will be the responsibility of the patient.
3. **Care Credit:**
   For your convenience our office participates with Care Credit. This is a 3rd party medical card which will allow you to complete your planned treatment at a low interest rate, and for some treatment interest free. Please see one of our administrative staff members for more information.
   - A $25.00 charge will be added to any account sent to collections.
   - Returned checks shall be subject to a $35.00 bad check fee.

Our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Patient/ Responsible Party Signature: Date:

Print Name: ______________________________

Witness Signature: Date:

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.