



**RONALD J. HOLLANDER, DDS**  
EXCELLENCE IN DENTISTRY

## Patient Information

*Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Cell  No Preference

Married  Widowed  Single  Minor  Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_

How much have you used? \_\_\_\_\_

Max. annual benefit? \_\_\_\_\_

## Dental History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of last exam \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X rays \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check any of the following conditions that apply to you: \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

## Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

(Women) Are you pregnant?  Yes  No    Nursing?  Yes  No    Taking birth control pills?  Yes  No

Check (✓) if you have had any of the following:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Hernia Repair        | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Shortness of Breath       |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood           | <input type="checkbox"/> HIV Positive         | <input type="checkbox"/> Skin Rash                 |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Swelling of Feet or Ankle |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Bleeding Abnormally     | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mural Valve Prolapse | <input type="checkbox"/> Tobacco Habit             |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Nervous Problems     | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Ulcer                     |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                    | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Respiratory Disease  |  |

Have you ever taken any of these medications?

**Diet Medications:**     Dexfenfluramine     Fen phen     Pondimin     Redux

**Blood Thinners:**     Coumadin     Warfarin

**Other:**     Levoxyl     Synthroid

## Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_

Name of Insurance Company (ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

## Authorization and Release

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 my information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependants. I also understand that I am responsible for any late or collection fees if payments is not rendered.

\_\_\_\_\_  
Signature of patient (or parent/guardian if minor)



Ronald J. Hollander, D.D.S.  
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[www.waldorfdental.com](http://www.waldorfdental.com)

125 St. Patrick's Drive  
Waldorf, MD 20603

Metro  
301.893.2000

Local  
301.638.2000

### **Broken Appointment Policy**

We appreciate your patronage and we will make every effort to schedule your appointment for the date and time that is most convenient for you. For your convenience we offer a "priority call list". If we receive a change in schedule for a day and time that works better for you, we will call you to move your appointment to the requested time.

For the above listed reason, our practice has a broken appointment policy that we strictly enforce. We ask that you give us at least 48 business hours if you need to change an appointment to avoid a broken appointment fee. The office is closed on Mondays. This would mean that if you have an appointment scheduled on Tuesday, we would need to receive a call by close of business Thursday. All broken appointments will be assessed a fee of \$50 per 30 minutes. Thank you for your understanding in this matter.

I understand this is a policy acquired by Dr. Hollander's office, and agree to abide by the terms indicated above.

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Responsible Party's signature

Date



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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payors; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices notice, which contains a complete description of the uses and disclosures of my health information. I understand that my dental provider has the right to change its Notices of Privacy Practices from time to time and that I may contact them at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I have the right with respect to my protected health information, that I may exercise by presenting a written request to the Privacy Officer. I understand that I have the right to request such restrictions on certain uses and disclosures. My dental provider is however, not required to agree to a requested restriction. If they do agree to a restriction, they must abide by it unless I agree in writing to remove it.

Patient Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Insurance Policy

We realize that patients have dental insurance to help cover the cost of their dental care; however, these are contracts between you and your insurance company. As a courtesy to our patients, we do everything possible to maximize the use of your insurance benefits, including submitting your dental claims for any reimbursement. If the insurance has not paid the claim within a 30-day period, the entire amount will be expected from the patient. Insurance reimbursements if any, will then be forwarded to the patient.

The fee quotes we give you are given to us by your insurance company, according to your contract. These quotes are estimates and not a guarantee of payment. All patient co-pays, are collected on every visit, however the total balance regardless of expected insurance is your responsibility. After we have received the insurance estimated portion, you will be billed for any remaining fees on the account.

All financial arrangements need to be made for your account, before your treatment begins.

## Secondary Insurance

We no longer accept secondary insurance as payment on your account. We will be more than happy to file the claims to the secondary insurance after all monies are paid on the account. All reimbursements if any from the secondary insurance will be sent directly to the patient.

I understand this is a policy acquired by Dr. Hollander's office, and agree to abide by the terms indicated above.

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Responsible Party's Signature

Date