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 hawe 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: _____

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ 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:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe_____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mural Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankle
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal 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. 1 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. 1 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. 1 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.
Excellence in Dentistry

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.

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.

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

Responsible Party's Signature Date