WE KNOW YOU HAVE A CHOICE…
THANKS FOR CHOOSING US!!

DELMARVA DENTAL SERVICES WILL THOROUGHLY EXPLAIN ALL DENTAL TREATMENT OPTIONS, PROVIDE TREATMENT THAT LOOKS AND FEELS GREAT, IS LONG LASTING, AND CREATES OPTIMUM DENTAL HEALTH.

DATE: _____

PATIENT INFORMATION:

Last Name: First Name: MI:

Preferred Name: Date of Birth: SSN:

Mailing Address:

Gender Identification: □M □F □Other □Single □Married

Employer/Occupation: Work#

Cell #: Home#: Email:

Preferred Contact Methods: □Call □Text □Email □Work

SPOUSE INFORMATION:

Last Name: First Name: MI:

Preferred Name: Date of Birth: Contact #:

ALTERNATE EMERGECY CONTACT (Name/Number): _____

DENTAL INSURANCE - Please also provide insurance card upon check in

Primary

Plan Name:	Policy Holder:
Group Number:	Member ID:

Secondary

Plan Name:	Policy Holder:
Group Number:	Member ID:

NEW PATIENT'S ONLY, Who Can we thank for referring you? : _____

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MEDICAL INFORMATION:

Current Health Status: □Poor □Fair □Good □Excellent

Primary Care Physician: Phone #:

Preferred Pharmacy (Name/Location):

Medications- RX/OTC, Supplements: (Please provide us with a list or write them here):

Have you ever had to pre-medicate with antibiotics prior to your dental appointment? □Yes □No

If yes, why?

Have you been hospitalized or had any surgeries within the past 2 years? □Yes □No

If yes, why?

Do you: (check all that apply):

□Smoke □Chew Tobacco □Use Recreational Drugs □Vape □Drink Alcohol

Females Only:

Are you pregnant? □Yes □No If Yes, when is your due date?

Are you nursing? □Yes □No

ALLERGIES (CHECK all that apply):

- □ Amoxicillin
- □ Clindamycin
- □ Erythromycin
- □ Penicillin
- □ Sulfa Drugs
- □ Epinephrine
- □ Local Anesthetic
- □ Nitrous Oxide
- □ Valium
- □ Aspirin/Ibuprofen/Acetaminophen
- □ Percocet
- □ Hydrocodone
- □ Codeine
- □ Latex
- □ Other:

_____

_____

_____

RESPIRATORY CONDITIONS (CHECK all that apply):

- □ Sinus Issues
- □ Tuberculosis
- □ Asthma
- □ COPD
- □ Lung Disease
- □ Meningitis

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HEART CONDITIONS (CHECK all that apply):

- □ Angina
- □ Heart Disease
- □ Heart Failure
- □ Stroke: Date_____
- □ Pacemaker: Date_____
- □ Stent: Date_____
- □ Heart Attack: Date_____
- □ Artificial Valve: Date_____

BLOOD CONDITIONS (CHECK all that apply):

- □ Blood Thinners
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Anemia
- □ Sickle Cell
- □ Hemophilia
- □ HIV/AIDS
- □ Hepatitis A/B/C

BONE CONDITIONS (CHECK all that apply):

- □ Joint Replacements: List below
  Date_____ Type_____
  Date_____ Type_____
- □ Arthritis
- □ Osteoporosis
- □ Rheumatism

MENTAL HEALTH CONDITIONS (CHECK all that apply):

- □ Depression/Anxiety
- □ Eating Disorder
- □ ADHD
- □ Recovering NA/AA
- □ Bipolar
- □ Unintentional Weight Loss/Gain
- □ Psychiatric Treatment
- □ Learning Problems

ABDOMINAL CONDITIONS (CHECK all that apply):

- □ Acid Reflux/GERD
- □ Gastrointestinal Issues
- □ Kidney Disease
- □ Liver Conditions

ONCOLOGY HISTORY (CHECK all that apply):

- □ Cancer: Date_____ Type _____
- □ Radiation: Date_____
- □ Tumor: Date_____ Area _____
- □ Chemo: Date_____

OTHER CONDITIONS (CHECK all that apply):

- □ Hearing Problems
- □ Vision Problems
- □ Fibromyalgia
- □ Herpetic Cold sores
- □ Ulcers
- □ Diabetes
- □ Organ Transplant:
  Date _____Area_____
- □ Dizzy Spells/Fainting
- □ Thyroid Issues
- □ Epilepsy/Seizures
- □ Hormone Therapy

Any other conditions not listed above:

_____

_____

Please initial if you have none of the above conditions:_____

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FINANCIAL AGREEMENT

The statements below must be READ and INITIALED prior to your appointment. Failure to do so may result in refusal of treatment.

1) I acknowledge that if my account becomes delinquent and goes to collections, all applicable collection fees will become my responsibility. _____(initial)
2) I acknowledge that if a check is returned from the bank, I will be charged a $30 fee. _____(initial)
3) I understand that I am responsible for all fees incurred by me or dependents on my account at Delmarva Dental Services. Any amount not paid by the insurance company will become my responsibility and I will pay the balance promptly. _____(initial)
4) Except in the case of an emergency, I acknowledge if I cancel my appointment with less than 24 hours' notice or do not appear for my appointment there will be a $50 fee applied to my account. _____(initial)

The medical information I have provided is complete and accurate to the best of my knowledge. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding this medical profile.

Name (please print) □ Patient □ Parent □ Guardian

Signature □Date

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Joseph P. Harmon, D.D.S. Leigh D. Auchey, D.D.S.

Jessica A. Harrison, D.D.S.

Delmarva Dental Services is Out-Of-Network with ALL insurance carriers.

What does this mean?

Our office is non-contracted with ALL insurance companies. Some plans require you to go to a contracted office. If your plan is like this, they will not pay anything for your visits with us.

Some dental plans allow you to go to any dentist you choose, however, your out-of-pocket costs are usually higher.

Information about insurance payments:

If your insurance does not pay us directly, we will collect the full fee from you. As a courtesy, we will send the claims to your insurance company, and you will receive the amount that they are going to reimburse directly from them.

If your insurance sends payment to us, we will estimate what they will pay towards the visit and collect your portion at that time. If the insurance pays less than what we estimated, we will send you a bill. If the insurance pays more than what we estimated, we will reimburse you in check form or you can leave it on your account here for future visits.

I acknowledge I have read the above information regarding my insurance plan and understand that Delmarva Dental Services is out-of-network with ALL insurance.

I also acknowledge that once my insurance payment has been received, any remaining balance is my responsibility, and payment is due in a timely manner.

Name: Date:

(Please print)

Signature:

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