Choice Dental Care
Dr. Ally & Dr. Scott
8667Georgia Avenue
Silver Spring, MD 20910
(301) 562-6020

WELCOME TO OUR PRACTICE. We are delighted you have chosen our office for your dental care. The staff is proud to have the opportunity to provide you with gentle, efficient and state of the art dental services. We hope to make your visit with us comfortable, relaxing, and yes, even enjoyable. Please take a moment to familiarize yourself with our office policies and procedures, and let us know if you have any questions or concerns anytime.

OFFICE POLICY
Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for your services in a timely manner.

Our staff can tell you the approximate fee for treatment before your appointment. To make payments convenient for you, we accept cash, Visa, MasterCard or American Express. **SORRY- WE DO NOT ACCEPT PERSONAL CHECKS.**

We expect insured patients to read their policy carefully and to become familiar with its benefits and limitations. Please bring an insurance card and a copy of the policy brochure to our office so we may assist you more completely.

It is important that you understand your insurance is designed to **assist** you with your financial obligation. They do not determine the treatment you need. They are a third party, hired by your employer, as a benefit to help defray the expense of dental treatment. **YOU ARE ULTIMATELY RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL, REGARDLESS OF YOUR INSURANCE COVERAGE.**

Established patients having insurance are expected to pay their **DEDUCTIBLE AND CO-PAYMENT ESTIMATE** at the time of service or as previously arranged with the financial coordinator. We can only **ESTIMATE** the approximate amounts an insurance carrier will reimburse. Most policies differ for each individual.

Any insurance payment not received after forty-five (45) days of filing becomes the responsibility of the patient. Payment from the patient is expected within ten (10) days of notification.

If an account is outstanding for more then sixty (60) days, a monthly service charge of 1.5% (18% per year) may be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service and a report may be filed with a credit servicing agency, such as Equifax.

Cancellation or Broken appointment Policy:
I understand that if I cancel any dental appointment without giving 24 hours notice on a business day, I will be subject to paying a $25.00 per half hour fee. Until the fee is paid, no further appointment will be scheduled.

Your time is as valuable as ours. We make every effort to see you at your reserved time. We apologize in advance if you are not seen exactly at your scheduled time; please understand that we do try to work-in dental emergencies.

As a courtesy we attempt to confirm each scheduled appointment, however, as the patient you are responsible to keep up with your reserved time and are still subject to the cancellation/broken appt. fee should you not make it to your appointment. Please inform us if any address or contact information needs to be updated.

I HAVE READ THE ABOVE POLICY AND AGREE TO ACCEPT ALL FINANCIAL RESPONSIBILITY FOR:

_______________________________________ _______________________________
PRINT PATIENT'S NAME RELATIONSHIP TO PATIENT

____ Date: ________________
***Signature** of patient*, Parent or Guardian (accompanying minor)

Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other __________

Social Security #: ________________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: _____ Cell: ______________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Address: ____
Street Apartment #

____
City State Zip Code

Are you happy with your smile? _________ What would you change? ____________________
How often do you floss? ____________ Are you having difficulty flossing? __________
Have you had orthodontic treatment in the past? _________Have your teeth shifted since treatment was complete?______
Are you aware the health of your mouth affects your overall health?____________
Did you know that you can now straighten teeth and improve your oral health with invisible, removable aligners? _______

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ____________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ ________________
☐ ________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ________________________________ Phone: ____________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ______________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Insurance Co. ☐ Walk In. ☐ Work ☐ Other ____________________

Name of person or office referring you to our practice: ______________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ____

____

Spouse or Responsible Party Information

The following must be completed before the patient is examined.
This is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female

Address: ____
Street City State Zip Code

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, **must be paid for in cash at the time services are performed.**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. In addition, this form also authorizes this practice to submit insurance claim forms and receive payments directly from the Insurance Carrier with the notation “SIGNATURE ON FILE”. I authorize my Dentist(s) to release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: __________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: __________
Signature of guarantor of payment/responsible part