ASUNCION DENTAL GROUP
A commitment to excellence, quality and caring dentistry

Dr. Frederick Asuncion, DDS.
Asuncion Dental Group
7101 Guildford Dr. #205
Frederick, MD 21704

PATIENT INFORMATION

Date: _____ ☐ New Patient ☐ Update

Patient: _____ (Last) _____ (First) _____ (Mi) _____ (Preferred) _____ (Title)

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW :

_____ (Parent/Guardian Name(s))

**IF STUDENT, PLEASE COMPLETE: ☐ Full-Time ☐ Part-Time

_____ (School/Location)

Patient Date of Birth: _____ Patient SSN: _____

Address: _____ (Address Line 1)

_____ (Address Line 2)

_____ (City) _____ (ST) _____ (ZIP Code)

E-mail: _____

Home: _____
Cell: _____
Other: _____
Pager: _____
Fax: _____

Referral? ☐ Yes ☐ No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ (Name) _____ (Relationship) Tel: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____ (Address Line 1)

_____ (Address Line 2)

_____ (City) _____ (ST) _____ (ZIP Code)

E-mail: _____

Work: _____
Direct: _____
Other: _____
Pager: _____
Fax: _____

INSURANCE INFORMATION

Subscriber: _____ (Last) _____ (First) _____ (Mi) _____ (Preferred) _____ (Title)

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Insurance Carrier: _____

Group/Policy No: _____ ID No: _____

Address: _____ (Address Line 1)

_____ (Address Line 2)

_____ (City) _____ (ST) _____ (ZIP Code)

Tel: _____
Toll-Free: _____
Other: _____

Secondary Insurance Carrier: _____

Group/Policy No: _____ ID No: _____

Address: _____ (Address Line 1)

_____ (Address Line 2)

_____ (City) _____ (ST) _____ (ZIP Code)

Tel: _____
Toll-Free: _____
Other: _____

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____
Address Line 1

_____
Address Line 2

_____ _____ _____
City *ST* *ZIP Code*

Reason for changing: _____

DENTAL HISTORY

Oral Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of Last Dental Visit: _____ **Treatment Type:** _____

☐ Yes ☐ No Are you currently having dental discomfort? If yes, explain: _____

☐ Yes ☐ No Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐ Yes ☐ No Any injuries to mouth/teeth/head? If yes, explain: _____

☐ Yes ☐ No Any missing teeth other than wisdom teeth or orthodontic extractions?

☐ Yes ☐ No Have missing teeth been replaced?

☐ Yes ☐ No Orthodontic appliances now or in the past?

☐ Yes ☐ No Gums bleed when brushing or flossing?

☐ Yes ☐ No Concerned about gum disease? History of gum disease? ☐ Yes ☐ No

☐ Yes ☐ No Any concerns about the appearance of your teeth?

☐ Yes ☐ No Does it hurt to bite or chew?

☐ Yes ☐ No Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐ Yes ☐ No

☐ Yes ☐ No Do you want to become a regular continuing care patient in our practice?

☐ Yes ☐ No Do you want your mouth properly restored and pain free?

☐ Yes ☐ No Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

What Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: *PLEASE ANSWER THE FOLLOWING QUESTIONS:*

☐ Yes ☐ No Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier,etc.)

_____

☐ Yes ☐ No Any unusual speech habits? If yes, explain: _____

☐ Yes ☐ No Any lost teeth? If yes, list: _____

☐ Yes ☐ No Does the patient receive assistance with brushing and flossing? If yes, how often?

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

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MEDICAL HISTORY

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Under a physician's care now?
☐ Yes ☐ No Any hospitalization in the past 5 years? _____
☐ Yes ☐ No Any serious illnesses/surgeries? _____
☐ Yes ☐ No Use tobacco in any form? If Yes, Type: _____
☐ Yes ☐ No Is pre-medication required before dental visits due to heart condition or artificial joint?
☐ Yes ☐ No Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐ Yes ☐ No *Currently nursing?* ☐ Yes ☐ No *Currently pregnant?* Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Yes ☐ No
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Yes ☐ No If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAO ANY OF THE FOLLOWING? *(CHECK ALL THAT APPLY):* ☐ NONE

☐ ACID REFLUX
☐ ADHD
☐ AIDS/HIV
☐ ANEMIA
☐ ANOREXIA
☐ ANXIETY
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINTS
☐ ARTHRITIS
☐ ASTHMA
☐ AUTISM/ASPERGER'S
☐ BLEEDING DISORDER
☐ BULIMIA
☐ CANCER/MALIGNANCY
☐ CEREBRAL PALSY
☐ CHEMICAL DEPENDENCY
☐ CHICKEN POX
☐ CONVULSIONS
☐ DEPRESSION
☐ DIABETES
☐ DIZZINESS/FAINTING
☐ EPILEPSY/SEIZURES
☐ FREQUENT EAR INFECTIONS
☐ FREQUENT HEADACHES
☐ HEARING PROBLEMS
☐ HEART ATTACK
☐ HEART DISEASE
☐ HEART MURMUR
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ LIVER PROBLEMS
☐ MITRAL VALVE PROLAPSE
☐ MONONUCLEOSIS
☐ PACEMAKER
☐ OTHER - *Please list:* _____
☐ PSYCHIATRIC TREATMENT
☐ RADIATION/CHEMO
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SINUS PROBLEMS
☐ STROKE
☐ THYROID CONDITION
☐ TUBERCULOSIS
☐ ULCERS
☐ VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAO ANY REACTION TO THE FOLLOWING? *(CHECK ALL THAT APPLY):* ☐ NONE

☐ ASPIRIN
☐ ANESTHETIC - LOCAL
☐ BARBITURATES
☐ CODEINE
☐ DAIRY
☐ LATEX
☐ LACTOSE INTOLERANCE
☐ METAL SENSITIVITY
☐ NITROUS OXIDE SEDATION
☐ SLEEPING PILLS
☐ SULFA DRUGS
☐ PENICILLIN/OTHER ANTIBIOTICS
☐ OTHER - *Please list:* _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? *(CHECK ALL THAT APPLY):* ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS
☐ BLOOD THINNERS
☐ INSULIN
☐ OTHER DIABETIC MEDICATIONS
☐ OTHER *(Please list below)*
☐ ANTIHISTAMINES/ALLERGY
☐ CANCER/CHEMO MEDICATIONS
☐ NITROGLYCERIN
☐ RECREATIONAL DRUGS
☐ DAILY ASPIRIN
☐ CORTISONE/STEROIDS
☐ ORAL CONTRACEPTIVES
☐ THYROID MEDICATIONS
☐ BLOOD PRESSURE MEDICATIONS
☐ HEART MEDICATION/DIGITALIS
☐ OSTEOPOROSIS MEDICATIONS
☐ TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and Identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health Information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the Notice *of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:** _____

RELATIONSHIP TO PATIENT: ☐ ADULT PATIENT ☐ PARENT ☐ GUARDIAN ☐ OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by Dr. Frederick Asuncion, DDS *(please check all that apply) :*

☐ Cell phone: _____ ☐ Text Message reminders permitted
☐ Home Phone ☐ Work ☐ E-Mail: _____

☐ I am granting permission for Dr. Frederick Asuncion, DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission Dr. Frederick Asuncion, DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers *(please check all that apply) :*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None·please just ask for a call back
☐ Other *(Please explain)* _____

I would like to give permission for the following person(s) to have access to personal Information Including but not limited to appointments, treatment, and billing of myself and·any dependent children listed·above.

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other - *Please list:* _____

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Financial, Insurance and Office Policies

Welcome to the office of Dr. Frederick Asuncion. We are happy to have you as a patient. Please take a moment to read the following office and financial policies as they were designed to help our office better serve you.

Office Goals: Our goal is to provide the highest caliber of dentistry in a professional but caring manner that makes our patients feel welcome and comfortable. Please let us know if you have special concerns or are nervous about receiving dental treatment. We will take extra measures in such cases to put you at ease.

Punctuality: We ask that you arrive on time for your appointments. Tardiness of even 10 or 15 minutes makes a significant difference in a dental office and can delay other patients for the remainder of the day.
We realize that all of our patients are busy and we make every attempt to adhere to our schedule. However, the nature of dentistry is that on occasion a procedure can take longer than anticipated because each patient is unique. In addition, our policy is to always make room for established patients when they have emergencies and this can unexpectedly delay our schedule. We ask for your patience in these cases and in return we will give you our undivided attention during your appointment.

Payment of Fees: Fees are due at the time services are rendered. Personal checks as well as Visa & MasterCard are accepted. Please come prepared to pay, as we cannot "bill" you or collect payment at a later time. We do take time to go over estimated expenses for treatment that is on your treatment plan. Please keep in mind that on occasion it is necessary to deviate from the treatment plan that was originally planned which may constitute an adjustment in fee. In certain circumstances extended payment options can be offered however these must be discussed prior to your visit.

Children: We request that a parent be present during the appointment of any child younger than 18 years of age. On occasion it is necessary to deviate from the treatment, which was originally planned, and parental consent is required to proceed.

A parent must supervise children who do not have an appointment. For your child's safety and that of others, please ensure that he/she remains in the front waiting room.

Divorced parents bringing a child to an appointment are solely responsible for all fees incurred during each visit. Parents will not be billed separately.

Cancellation Fees: A fee will be assessed to any patient who does not show up for an appointment, or who cancels an appointment with less than 48 business hours notice. This cancellation fee will be due in our office before any subsequent appointments can be scheduled.

Past Due Accounts: Past due accounts that result in being sent to collections, will be charged a processing fee that will be the responsibility of the responsible party/guardian on the account. Returned checks will be subject to a $35 NSF fee.

Insurance Policy:
We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our Insurance payment policy.

Dental benefit plans can vary from company to company with different procedures covered or not covered. In other words your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into most plans and state law mandates that our office collect these payments at the time of treatment.

As a courtesy to our insured patients we will make a concerted effort to help you receive maximum insurance benefits including filing claims in a timely manner and submitting claims with documentation necessary to facilitate prompt payment. You will be responsible for any unpaid insurance claims after 30 days from that date of service, regardless of the reason for denied payment.

We must emphasize that as dental care providers our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If payment problems so arise, we encourage you to contact us promptly for assistance in the management of your account.

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AUTHORIZATION/RESPONSIBILITY AGREEMENT

I hereby authorize the office of Dr. Frederick Asuncion

- to administer such medications and perform such diagnostic and therapeutic procedures as my be necessary for proper dental care. The information I have given including dental and medical histories are correct to the best of my knowledge. I also understand it is very important to report any changes in my medical or dental status to my provider at the earliest possible time, and I agree to do so.

- to release any information concerning health or dental care, advice, treatment or supplies, provided this information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I further understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I have read the financial and office policies and agree to uphold them while I am a patient in this office.

Signature: _____ **Date:** _____