Hagert Family Dentistry, LLC

Pelczar Professional Building ● 415 Washington Avenue, #1 ● Chestertown, MD 21620

Phone: (410) 778- 2474 ● Fax: (410) 778-1942

Patient Information

Patient Name: _____ Today's Date: _____
Last First MI

Address: _____
Street Apartment #

_____
City State Zip Code

Birth Date: _____ Social Security #: _____ Marital Status: ____ Sex: ____

Email: _____

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

Employer: _____ Occupation: _____

Person Responsible for Account: _____ Referred By: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Dental Insurance Information

Do you currently have Dental Insurance? ☐ Yes ☐ No if yes please fill out dental 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: _____

Patients' Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

Dental Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

Date of Last X-rays: _____
Bitewing Panoramic/Full Mouth Series

Reason for Today's Visit: _____

_____

_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain_____

_____

Do you pre-medicate for dental appointments? ☐ Yes ☐ No If so, why? _____

_____

Medical Health Information

Name of Physician: _____ Phone: _____
Name of Pharmacy: _____ Phone of Pharmacy: _____
Are you now under the care of a physician? ☐ Yes ☐ No Why? _____
_____
Do you smoke or use tobacco? ☐ Yes ☐No
Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain _____
_____

Medical History Continued

IF APPLICABLE…
Please list osteoporosis medications: _____
Please list blood thinner medications: _____
Please list biologic medications: _____

Please list all other medications you are currently taking:

Please check yes or no to the following conditions listed below:

Y N **Conditions**	Y N **Conditions**	Y N
☐ ☐ Abnormal Bleeding	☐ ☐ Heart Surgery	☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Alcohol Abuse	☐ ☐ Heart Murmur	☐ ☐ Are you pregnant?
☐ ☐ Allergies	☐ ☐ Hemophilia	If yes, # of weeks _____
☐ ☐ Anemia	☐ ☐ Hepatitis _____	☐ ☐ Are you nursing?
☐ ☐ Angina Pectoris	☐ ☐ High Blood Pressure	
☐ ☐ Arthritis	☐ ☐ HIV+ AIDS	☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered in conditions listed?
☐ ☐ Artificial Joints/ Replacement	☐ ☐ Kidney Problems	If yes, please explain below… _____
☐ ☐ Artificial Heart Valve	☐ ☐ Liver Disease	_____
☐ ☐ Asthma	☐ ☐ Low Blood Pressure	_____
☐ ☐ Blood Transfuser	☐ ☐ Lung Disease	_____
☐ ☐ Cancer- Chemotherapy	☐ ☐ Lupus	
☐ ☐ Colitis	☐ ☐ Mental Disorders	
☐ ☐ Congenital Heart Defect	☐ ☐ Mitral Valve Prolapse	
☐ ☐ Cosmetic Surgery	☐ ☐ Nervous Disorders	
☐ ☐ Depression	☐ ☐ Pace Maker	
☐ ☐ Diabetes	☐ ☐ Prescribed Weight Loss Meds	
☐ ☐ Difficulty Breathing	☐ ☐ Radiation Therapy	
☐ ☐ Dizziness	☐ ☐ Respiratory Problems	
☐ ☐ Drug Abuse	☐ ☐ Rheumatic Fever	
☐ ☐ Emphysema	☐ ☐ Seizures	
☐ ☐ Epilepsy	☐ ☐ Shingles	
☐ ☐ Excess Bleeding	☐ ☐ Sickle Cell Disease	
☐ ☐ Fainting Spells	☐ ☐ Sinus Problems	
☐ ☐ Fever Blisters	☐ ☐ Stroke	
☐ ☐ Frequent Headaches	☐ ☐ Thyroid Problems	
☐ ☐ Glaucoma	☐ ☐ Tuberculosis	
☐ ☐ Head Injuries	☐ ☐ Tumors	
☐ ☐ Hay Fever	☐ ☐ Ulcers	
☐ ☐ Heart Attack	☐ ☐ Venereal Disease	
☐ ☐ Heart Defect	☐ ☐ Yellow Jaundice	
☐ ☐ Heart Disease		

Y N **Allergies**
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Dental Anesthetics
☐ ☐ Erythromycin
☐ ☐ Jewelry
☐ ☐ Latex
☐ ☐ Metals
☐ ☐ Penicillin
☐ ☐ Tetracycline
☐ ☐ Other:
_____

Signature: _____ **Date:** _____

(If Under 18, Parent of Guardian Signature Required)

Office Dental Insurance Information and Financial Policies

Welcome to our office. Thank you for choosing Hagert Family Dentistry, LLC for your dental needs. We are committed to quality care and pride ourselves in making dentistry a pleasant experience. Our primary goal, whenever possible, is the retention of your natural teeth and good oral health. We have found that achievement of this goal necessitates a partnership of mutual respect and responsibility. We ask for your full participation in this endeavor and would like to acquaint you with our policies regarding dental insurance, payments, reservation changes, etc.

Dental Insurance

If you have dental insurance, as a service to you, we will submit all claims to the insurance company with all the necessary information and x-rays. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

I authorize and release information and payment of my dental insurance to the dentist.

Payments

We accept payment by Cash, Personal Check, MasterCard, Discover, American Express or Visa.
If you need to make long-term payments, you may qualify for a long-term payment option offered through one of our financial partnerships. Please see our front office staff for more details.

Credits

It is the patient's responsibility alone to inquire about the possibility of a credit on his or her account. If the patient would like to receive a refund check, please contact our office and speak to a team member so that request may be processed.

Reservation Changes

When a reservation is made, the time is specifically set aside for you and your treatment. We value this time and ask that you honor your commitment to your reservation. We reserve the right to charge for appointments broken or rescheduled without the proper 2 business day notification.

I have read and understand fully the policies as outlined above. I agree to accept responsibility for payment of my bill including co-pays, deductibles, or non-covered services requested by me. I understand that if my account becomes delinquent, I will be responsible for, and agree to pay, any collection costs including but not limited to, collection agency fees, attorney's fees, court costs, interest, and any other charges incurred to collect on my account.

_____ _____

Signature of patient or guardian Date

Smile Assessment Form

Please consider each statement carefully and circle **YES** or **NO**. The doctor and members of the dental team will discuss your response with you in confidence.

1.	I am concerned about the appearance of my teeth or my smile.	YES	NO
2.	I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3.	I am concerned about the position or angle of one or more of my teeth.	YES	NO
4.	I am concerned about the shape of one or more of my teeth.	YES	NO
5.	In social situations, I am sometimes embarrassed by my teeth or my smile.	YES	NO
6.	There are some things about my upper front teeth that I would like to change.	YES	NO
7.	There are some things about my lower front teeth that I would like to change.	YES	NO
8.	I clench and grind my teeth.	YES	NO
9.	I have receding gums or gums that bleed.	YES	NO
10.	I have bad breath or dry mouth.	YES	NO
11.	I am missing one or more of my teeth.	YES	NO
12.	I have previous dental work that no longer satisfies me.	YES	NO
13.	I am interested in learning more about esthetic dentistry.	YES	NO
14.	It has been more than 2 years since my last dental visit.	YES	NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

_____

_____

_____

_____

_____

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