Hagert Family Dentistry, LLC
Pelczar Professional Building ● 415 Washington Avenue, #1 ● Chestertown, MD 21620
Phone: (410) 778- 2474 ● Fax: (410) 778-9452

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 HPV Vaccinated? ☐ 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**
☐ ☐ Abnormal Bleeding
☐ ☐ Alcohol Abuse
☐ ☐ Allergies
☐ ☐ Anemia
☐ ☐ Angina Pectoris
☐ ☐ Arthritis
☐ ☐ Artificial Joints/ Replacement
☐ ☐ Artificial Heart Valve
☐ ☐ Asthma
☐ ☐ Blood Transfuser
☐ ☐ Cancer- Chemotherapy
☐ ☐ Colitis
☐ ☐ Congenital Heart Defect
☐ ☐ Cosmetic Surgery
☐ ☐ Depression
☐ ☐ Diabetes
☐ ☐ Difficulty Breathing
☐ ☐ Dizziness
☐ ☐ Drug Abuse
☐ ☐ Emphysema
☐ ☐ Epilepsy
☐ ☐ Excess Bleeding
☐ ☐ Fainting Spells
☐ ☐ Fever Blisters
☐ ☐ Frequent Headaches
☐ ☐ Glaucoma
☐ ☐ Head Injuries
☐ ☐ Hay Fever
☐ ☐ Heart Attack
☐ ☐ Heart Defect
☐ ☐ Heart Disease

Y N **Conditions**
☐ ☐ Heart Surgery
☐ ☐ Heart Murmur
☐ ☐ Hemophilia
☐ ☐ Hepatitis _____
☐ ☐ High Blood Pressure
☐ ☐ HIV+ AIDS
☐ ☐ Kidney Problems
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure
☐ ☐ Lung Disease
☐ ☐ Lupus
☐ ☐ Mental Disorders
☐ ☐ Mitral Valve Prolapse
☐ ☐ Nervous Disorders
☐ ☐ Pace Maker
☐ ☐ Prescribed Weight Loss Meds
☐ ☐ Radiation Therapy
☐ ☐ Respiratory Problems
☐ ☐ Rheumatic Fever
☐ ☐ Seizures
☐ ☐ Shingles
☐ ☐ Sickle Cell Disease
☐ ☐ Sinus Problems
☐ ☐ Stroke
☐ ☐ Surgery: _____
☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis
☐ ☐ Tumors
☐ ☐ Ulcers
☐ ☐ Venereal Disease
☐ ☐ Yellow Jaundice

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant?
If yes, # of weeks _____
☐ ☐ Are you nursing?

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered in conditions listed?
If yes, please explain below… _____
_____
_____
_____

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.

Missed Appointment Policy

Missed appointments is defined as (A) an appointment that you do not show up for or (B) an appointment that you provide less than 48-hour notice to cancel or reschedule, in the event this happens you will be charged a **$50.00** cancellation fee.

If you have not confirmed your appointment 48 hours prior to your appointment, we reserve the right to reschedule you.

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.

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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