



Thank you for choosing Tidewater Dental as your new dental health care provider. We are certain you will find your Tidewater Dental experience to be above and beyond your past experiences and expectations.

Enclosed with this letter please find the following materials:

- **New Patient paperwork**—to be filled out at your leisure, before your first appointment.
- **Broken Appointment Policy**—highlighting our policy, so there are no misunderstandings.

If at any time, for any reason, you feel the need to contact us regarding service or suggestions, please contact me personally. I will be more than happy to address any questions, comments or concerns. You are our top priority at Tidewater Dental.

Sincerely,

Jeff Tomcsik

Business Administrator

Tidewater Dental

Jeff@TidewaterDental.com



Registration & Treatment

Date _____

Home Phone (____) _____

Patient Information

Name _____ SS#/ID# _____
Last First Middle

Address _____ Birth date ____/____/____ Age _____

City _____ State _____ Zip _____ Sex Male Female

Cell Phone (____) _____ E-Mail Address _____

How do you prefer to be contacted for appointment reminders? Telephone E-mail Text message

Patient Employer _____ Occupation _____

Business Address _____ Business Phone (____) _____

Whom may we thank for referring you? _____

In case of an emergency who should we notify? _____ Phone (____) _____

Primary Insurance

Person Responsible for account _____
Last First Middle

Relationship to Patient _____ Birth date ____/____/____ SS#/ID# _____

Address (if different from patient) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible employed by _____ Occupation _____

Business Address _____ Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependants covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? Y N

Subscriber Name _____ Relationship to Patient _____ Birth date ____/____/____

Address (if different form patient) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependants covered by this plan _____

Medical History and Information

Full Name: _____

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-Ray _____

Please check (/) if you have problems with the following

- Bad Breath Grinding teeth Sensitivity to hot or cold Bleeding Gums Sensitivity to sweets Loose teeth / broken fillings
 Clicking / popping jaw Sensitivity when biting Food collection b/w teeth Sores or growths in your mouth

Conditions

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Other Conditions (list) _____ |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Surgery | _____ |
| <input type="checkbox"/> Allergies (environmental) | <input type="checkbox"/> Hemophilia | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A | |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hepatitis B | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis C | |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Replacement | |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Radiation Therapy | |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually Transmitted Disease | |
| <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sickle Cell Disease | |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> HIV+ Aids | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers | |

Allergies

- Aspirin
 Codeine
 Dental Anesthetics
 Erythromycin
 Latex
 Metals
 Penicillin
 Sulfa
 Tetracycline
Other: _____

- Y N
 Do you use tobacco?

If Female

- Y N
 Are you taking Birth Control Pills?
 Are you pregnant?
If yes, # of weeks: _____
 Are you Nursing? _____

Smile Analysis

- Y N
 Are you interested in Invisalign (invisible braces)?
 Are you interested in teeth whitening?
 Are you interested in a cosmetic consultation?
 Are you interested in dental implants?

Name of General Physician: _____

Please list any medications you are currently taking: _____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is under 18 years old or requires a guardian:

PARENT/ GUARDIAN SIGNATURE

DATE

Print Patient Name / Guardian Name

OFFICE USE: Authorized Personnel Initials _____



Broken Appointment Policy

Tidewater Dental knows your time is valuable, and we respect that! In fact, we make it a point to schedule all of our patients with this in mind. Our daily goal is to seat all of our patients on time. In an effort to provide timely service to our patients we never over-book our schedule like so many other health care facilities. This makes our time very valuable to us as well. Therefore, in an effort to avoid broken appointments and late patient arrivals, the following policy has been adopted:

1. All cancellations or rescheduled appointments must be arranged two business days prior to appointment date.
2. Patients arriving more than ten minutes late may be rescheduled at *Tidewater Dental's* discretion.
3. Patients who...
 - are late,
 - don't show up for their appointment, or
 - reschedule without two business days notice

...will be required to supply us with a valid credit card to secure their rescheduled appointment. No charges shall be placed on the credit card so long as the next appointment is met or rearranged two or more business days prior to the new appointment date. Should the next appointment be broken without following the above guidelines, a \$75.00 missed appointment fee will be charged to the patient's credit card.

To avoid raising our dental fees and allow for all of our patients to reserve appointment times when desired, we find it necessary to implement this policy.

Thank you for understanding and respecting our time and policy. If you have any questions regarding this matter, please contact Jeff Tomcsik at 301-862-3900.

Please sign _____



Financial Policy

Payment is expected at the end of each appointment. For your convenience we offer several payment options including cash, check, debit card (w/ Visa or Master Card logo), credit card and direct ACH checking account debits. For bills in excess of \$2,500 we will gladly help you acquire third party financing (when available).

If you are using Dental Insurance to help with payment, your co-pay will be due at the time of service. We will be happy to file your claim for you, however, **your bill is ultimately your responsibility** should insurance not cover the expected amount due.

For alternative payment arrangements we require that a valid credit card be held on file. Should you fail to meet your obligation, we may process your credit card for any outstanding balances.

This is necessary for us to maintain the level of services and care that all of our patients expect of us. If you have any questions about our financial policy, please feel free to contact our Financial Administrator at your convenience.

Credit Card Type (circle one): **Visa** **Master Card** **American Express** **Discover**

Card # _____

Expiration Date: ____/____

CVV code: _____

I authorize Tidewater Dental and Associate to process any outstanding balances on my account to the credit card listed above.

Signature

Date

Print Name



Acknowledgement of Receipt of Privacy Practice Notice

I, _____, acknowledge that I have received a notice of privacy practices from Tidewater Dental Associates.

Signature: _____ Date: ____/____/____

If a personal representative signs this authorization on behalf of the individual receiving treatment, complete the following:

Personal Representative's name: _____

Relationship to individual receiving treatment: _____