WELCOME

About You

Today's Date: ___/___/_____ Email Address: _____

Name: _____ I prefer to be called: _____ □ Male □ Female

Last First Middle Mr/Mrs/Ms/Dr

Birthdate: ___/___/_____ Age: ___ Social Security #: _____ □ Single □ Married □ Divorced □ Widowed □ Separated

Home Address: _____

Street City State Zip

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

Driver License #: _____

Where and when are the best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation:_____

Employer's Address: _____

Street City State Zip

Neighbor or Relative not living with you

Name: _____ Relation: _____

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

Home Address: _____

Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____

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

Driver License #: _____ Social Security #: _____

Employer: _____

Billing Address: _____

Street City State Zip

Spouse Information

Name: _____ Birthdate: ___/___/_____ Social Security #: _____

Cell Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: ___ Employer: _____

Insurance Information

Primary Insurance Dental Coverage? □ Yes □ No Medical Coverage? □ Yes □ No Orthodontic Coverage? □ Yes □ No

Insurance Co. Name: _____ Phone #: (_____)_____

Group # (Plan, Local, or Policy #): _____ Member ID# _____

Insurance Co. Address: _____

Street City State Zip

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/_____ Insured's Social Security #: _____

Insured's Employer: _____

Employers Address: _____

Street City State Zip

Dental History

Why have you come to the dentist today?

_____

Are you currently in pain? □ Yes □ No
Do you require antibiotics before treatment? □ Yes □ No
Have you experienced problems associated with any previous dental work? □ Yes □ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? □ Yes □ No
Your current dental health is: □ Good □ Fair □ Poor
Do you floss daily? □ Yes □ No
Brush daily? □ Yes □ No
Type of bristles on your toothbrush? □ Hard □ Medium □ Soft
How long do you use a toothbrush before replacing it? _____
Do you use anything in addition to your brush and floss? □ Yes □ No
If yes, what? _____
Would you like fresher breath? □ Yes □ No
Whiter teeth? □ Yes □ No

Do your gums ever bleed? □ Yes □ No
Ever itch? □ Yes □ No
Have you ever had periodontal disease? □ Yes □ No
Do you have mobility in your teeth? □ Yes □ No
Are your teeth sensitive to hot, cold, or anything else? □ Yes □ No
Do you still have your wisdom teeth? □ Yes □ No
Previous/Present Dentist: _____
Last Visit: ____/____/_____
Why did you leave your previous dentist? _____
_____
What did you like most and least about any dentist you have seen?
_____
Are you happy with the way your smile looks? □ Yes □ No
If not, what would you change? _____
_____

Medical History

Do you have a personal physician? □ Yes □ No
Physician's Name: _____
Address: _____
Street
_____
City State Zip
Phone #: (_____)_____Date of last visit: ____/____/_____
Your current physical health is: □ Good □ Fair □ Poor
Are you currently under the care of a physician? □ Yes □ No
Please explain: _____
_____
Do you smoke or use tobacco in any form? □ Yes □ No

Are you allergic to any of the following?

□ Y □ N Aspirin □ Y □ N Erythromycin □ Y □ N Sedatives
□ Y □ N Barbiturates □ Y □ N Jewelry/Metals □ Y □ N Sulfa Drugs
□ Y □ N Codeine □ Y □ N Latex □ Y □ N Tetracycline
□ Y □ N Dental Anesthetics □ Y □ N Penicillin □ Y □ N Other

Please list additional drugs/materials that cause allergic reactions:
_____
For Women: Are you taking birth control pills? □ Yes □ No
Are you pregnant? □ Yes □ No □ Unsure
Week #:_____ Are you nursing? □ Yes □ No

Are you taking any of the following?

□ Y □ N Acetaminophen □ Y □ N Blood Thinners □ Y □ N Insulin/Diabetes Drugs □ Y □ N Thyroid Medicine
□ Y □ N Antibiotics □ Y □ N Blood Pressure Medication □ Y □ N Nitroglycerin □ Y □ N Tranquilizers
□ Y □ N Antihistamines □ Y □ N Cold Remedies □ Y □ N Recreational Drugs
□ Y □ N Aspirin □ Y □ N Digitalis/Heart Medication □ Y □ N Steroids/Cortisone

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins, or minerals no listed above? □ Yes □ No If yes, please list each one:
_____

Do you or have you experienced the following?

□ Y □ N Abnormal Bleeding □ Y □ N Drug Abuse □ Y □ N High Blood Pressure □ Y □ N Scarlet Fever
□ Y □ N Alcohol Abuse □ Y □ N Emphysema □ Y □ N HIV/AIDS □ Y □ N Seizures
□ Y □ N Anemia □ Y □ N Epilepsy □ Y □ N Hospitalized for Any Reason □ Y □ N Shingles
□ Y □ N Arthritis □ Y □ N Fainting Spells □ Y □ N Kidney Problems □ Y □ N Sickle Cell Disease
□ Y □ N Artificial Bones/Joints □ Y □ N Fever Blisters □ Y □ N Liver Disease □ Y □ N Sinus Problems
□ Y □ N Artificial Valves □ Y □ N Glaucoma □ Y □ N Low Blood Pressure □ Y □ N Steroid Therapy
□ Y □ N Asthma □ Y □ N Hay Fever □ Y □ N Lupus □ Y □ N Stroke
□ Y □ N Blood Transfusion □ Y □ N Headaches □ Y □ N Mitral Valve Prolapse □ Y □ N Thyroid Problems
□ Y □ N Cancer □ Y □ N Heart Attack □ Y □ N Osteoporosis/Paget's Disease □ Y □ N Tonsillitis
□ Y □ N Chemotherapy □ Y □ N Heart Murmur □ Y □ N Pacemaker □ Y □ N Tuberculosis
□ Y □ N Chicken pox □ Y □ N Heart Surgery □ Y □ N Persistent Cough □ Y □ N Ulcers
□ Y □ N Colitis □ Y □ N Hemophilia □ Y □ N Psychiatric Problems □ Y □ N Venereal Disease
□ Y □ N Congenital Heart Defect □ Y □ N Hepatitis □ Y □ N Radiation Treatment
□ Y □ N Diabetes □ Y □ N Herpes □ Y □ N Rheumatic Fever

Please list any serious medical condition(s) that you have experienced: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

Payment is due at the time of service

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign Dr. David Kitahara and Dr. Bryan Kitahara all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

David J. Kitahara, D.D.S.
Bryan J. Kitahara, D.D.S.
8339 Cherry Lane
Laurel, MD 20707
301-498-0545

Appointment Policy

We make every effort to see all patients on time and request that you extend the same courtesy to us. Appointment times are reserved exclusively for you and will be scheduled at times best suited for the treatment involved. Any changes in appointments greatly affect other patients.

We require a minimum notice of **48 hours** for any appointment changes. A fee of $88.00 will be charged for broken appointments or short notice changes. This fee must be paid prior to any future treatment.

Financial Policy

In our efforts to keep dental cost at a minimum while maintaining a high level of professional care, we have established the following payment policies:

- Patients without Insurance Coverage: **Payment is expected at the time of treatment and may be paid for by**:
  - Personal Checks (with proper identification)
  - Cash
  - Credit Card (Visa, MasterCard, Discover, Care Credit)
- Patients with Insurance Coverage
  - Insurance Plans are accepted (we do not accept any HMO plans) providing that verification of eligibility has been made prior to the appointment and that we can accept the Assignment of Benefits. It is the patient's responsibility to verify the doctor is a listed participant with the insurance company plan prior to the appointment.
  - **Deductibles and Estimated Patient Portions not covered by insurance will be collected at the time services are rendered.**
  - All fees related to treatment are the full responsibility of the patient. In the event that payment is not received within 60 days from the treatment or the insurance payment varies from the estimated portion, the remaining balance will become the responsibility of the patient.
- Treatment consisting of several visits will require an appropriate down payment with the balance due upon completion.
- Payment plans are available and arrangements (signed completed financial agreement) **must be made in advance** of treatment. Providing that credit qualifications are met, payment plans will require an appropriate down payment and may be subject to monthly finance charges.
- **Account balances are due upon a receipt of statement from our office**. Account balances not paid within 25 days from the statement date will be subject to a service charge of $5.00.
- Any charges incurred by this office related to collection of overdue accounts will be added to the patient's account.
- A fee of $30.00 will be charged for any returned checks.

We hope this information is helpful in answering some of the questions you may have regarding our office policies. Please feel free to discuss any questions you may have with us.

I have fully read the above information and agree with the terms and conditions.

_____ _____

Patient/Responsible Party Signature **Date**

David J. Kitahara, D.D.S.
Bryan J. Kitahara, D.D.S.
8339 Cherry Lane
Laurel, MD 20707
Website: www.laurellakesdentist.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVATE PRACTICES

Notice of Privacy Practices: You have the right to read our NPP before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice has been posted in our office, on our website and a paper copy available upon request.

We reserve the right to make revisions of our privacy practices as described in our NPP. If we make any changes, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. ***Revised 9/23/2013***

I have read a copy of this office's Notice of Privacy Practices and have considered the contents of this consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)