Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

Patient Information

Patient Name: _____ **Date:** _____
Last, First MI (Preferred Name)

Gender: M ☐ F ☐ **Birthdate** _____ **Soc. Sec.:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Home Phone: _____ **Work Phone:** _____ Ext. _____**Mobile Phone:** _____

Address: _____
Street City State Zip Code

E-mail: _____ ☐ I would like to receive correspondences via e-mail

Employer Name: _____ **Status:** ☐ Full ☐Part-Time ☐Retired

Address: _____
Street City State Zip Code

Responsible Party

Name: _____
Last, First, MI (Preferred Name)

Home Phone: _____Work Phone: _____ Ext. _____ Mobile Phone: _____

Address: _____
Street City State Zip Code

Employer Name: _____ **Status:** ☐ Full ☐Part-Time ☐Retired

Address: _____
Street City State Zip Code

Emergency Contact

Contact Name: _____ **Mobile Phone:** _____

Referral Information

Whom may we thank for referring you to our office? _____

Dental Insurance Information

Name of insured_____ **Relationship to patient**_____

Birthdate_____**SS#**_____

Name of employer_____ Work phone_____

Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

Address of employer_____

Insurance company _____Ins. Co. address_____

Member/Subscriber ID# _____ **Group #** _____ Ins. Co. phone_____

Do you have any additional insurance? ☐ Yes ☐ No ***If yes complete below.***

Name of insured_____ **Relationship to patient**_____

Birthdate_____**SS#**_____

Name of employer_____ Work phone_____

Address of employer_____

Insurance company _____Ins. Co. address_____

Member/Subscriber ID# _____ **Group #** _____ Ins. Co. phone_____

Health Information

Physician's name: _____ Physician's phone: _____

Most recent visit to physician? _____ Reason: _____

Do we have permission to consult with your physician? ☐Yes ☐No

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? ☐Yes ☐No

If yes, for what condition _____

When was your last complete physical including blood tests? _____

Have you been hospitalized or had major surgery? ☐Yes ☐No

If yes, please explain: _____

Have you ever been advised to take antibiotics before dental appointment? ☐Yes ☐No

If yes, please explain: _____

Have you ever had a serious medical trouble associated with any dental experience? ☐Yes ☐No

If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐Yes ☐No

If yes, please explain: _____

Are you currently receiving **intravenous** Bisphosphonates? ☐Yes ☐No

If yes, for how long: _____

Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

Do you take, or have taken, Phen-fen or Redux? ☐Yes ☐No

If yes, please explain: _____

Do you take, or have taken, Zometa or Fosamax? ☐Yes ☐No

If yes, please explain: _____

Do you smoke or use other tobacco products? ☐Yes ☐No

If yes, please explain: _____

Are you **allergic** to any of the following substances?

☐Aspirin ☐Penicillin ☐Tetracycline ☐Erythromycin ☐Sulfa ☐Latex
☐Acrylic ☐Metal ☐Barbiturates ☐Dental Anesthetic ☐Tranquilizers ☐Codeine
☐Other: _____

Have you ever had an **adverse reaction** (nausea, dizziness, hives, rash, difficulty breathing, etc.) with any **medicine?**

☐Yes ☐No If yes, please explain which medicine & type of reaction

_____

Please mark any past or current conditions:

- ☐ Jaw Joint Pain
- ☐ Arthritis / Gout
- ☐ Venereal Disease
- ☐ Epilepsy / Seizures
- ☐ Ulcers
- ☐ Osteoporosis/Osteopenia
- ☐ Organ Transplant
- ☐ Depression / Anxiety
- ☐ Severe Headaches/Migraines
- ☐ Artificial Joint(s)
  If yes, which joint(s): _____ Date of Replacement(s): _____
- ☐ Liver Condition
  If yes, indicate condition(s) (circle): Jaundice; Cirrhosis; Hepatitis Type A, Type B, Type C, Non-specific
- ☐ Cancer
  If yes, type: _____
  Treatment (**circle all that apply**): Surgical Chemotherapy Radiation
- ☐ Impaired Eyesight / Glaucoma
- ☐ Hearing Aid / Hearing Disorder
- ☐ Kidney Condition: Shunt / Dialysis
- ☐ Frequent Mouth Sores or Lesions
- ☐ Positive HIV; AIDS; AIDS related complex
- ☐ Autoimmune disorder
- ☐ Parkinson's Disease
- ☐ Drug / Alcohol Addiction
- ☐ Steroid (prednisone cortisone) Therapy

Endocrine:

- ☐ Thyroid Disease
- ☐ Diabetes

Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

If yes, complete the following: Your last Hemoglobin A1c: _____

(Circle) Type I Type II How often do you have HbA1c tested? 3mo 6mo 12mo

Do you require Insulin? ☐Yes ☐No

How often do you check your blood sugar: _____

Circulation:

☐	Arterio / Atherosclerosis	☐	Heart Surgery: (circle) Bypass, Valve, Other
☐	High Cholesterol	☐	Rheumatic Fever; Rheumatic Heart Disease
☐	High / Low Blood Pressure	☐	Pacemaker; If yes, Date placed:_____
☐	Mitral Valve Prolapse	☐	Heart Attack(s); If yes, date: _____
☐	Heart Murmur	☐	Stroke
☐	Angina (chest pain)	☐	Blood / Bleeding Disorder
☐	Congestive Heart Failure	☐	Congenital Heart Defect

Respiratory:

☐	Chronic Lung Disease	☐	Tuberculosis
☐	Asthma	☐	Ever Exposed to TB
☐	Hay Fever / Allergies	☐	Persistent Cough or Cough up Blood
☐	Emphysema	☐	Chronic Sinus problems

☐ **Current** Use of Tobacco

Type: (circle) Cigarettes/Snuff / Chew/Cigar/Pipe How many per day? _____ Years of Use _____

☐ **Past history** of Tobacco Use If yes, When quit _____

Women Only:

☐ Pregnant / Trying to become pregnant If yes, expected delivery date: _____

☐ Nursing ☐ Taking Contraceptives ☐ Are you going or gone through menopause

Dental Health History

Name of previous Dentist: _____ Date of last exam: _____

Do your gums bleed while flossing or brushing?	☐Yes ☐No	
Do you experience sensitivity to hot/cold/sweet/sour?	☐Yes ☐No	
Do you feel pain to any of your teeth?	☐Yes ☐No	
Do you have any sores or lumps in or near your mouth?	☐Yes ☐No	
Have you had any head, neck or jaw injuries?	☐Yes ☐No	
Have you ever experienced the following problems with your jaw?	Clicking	☐Yes ☐No
	Pain (joint, ear, face)	☐Yes ☐No
	Difficulty opening/closing/chewing	☐Yes ☐No
Do you have frequent headaches?	☐Yes ☐No	
Do you clench or grind your teeth?	☐Yes ☐No	

Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

Do you bite your lips or cheeks frequently?	☐Yes ☐No	
Have you ever had any difficult extractions?	☐Yes ☐No	
Have you ever had prolonged bleeding following extractions?	☐Yes ☐No	
Have you ever had orthodontic treatment?	☐Yes ☐No	
Do you wear dentures or partials?	☐Yes ☐No	If yes, date of placement _____
Have you ever had oral hygiene instructions for teeth and gums?	☐Yes ☐No	
Do you like your smile?	☐Yes ☐No	

Herbal Medication / Supplements / Prescriptions:

Are you taking any of the following herbal medications supplements? **(Circle any / all that apply)**

Echinacea Licorice Ginseng Ephedra/Ma Huang Garlic/Ajo St. John's Wort
Gingko Valerian Ginger Coenzyme/Q10 Feverfew Goldenseal Saw Palmetto

Please list all: Prescription medications, herbal medications (other than indicated above) & vitamins or supplements that you are currently taking.

Name of Medication Dosage Condition / Reason you are taking

_____
_____
_____
_____

Cancelation/Missed appointment Policy

Patients are to notify the office **during business hours** and **greater than 48 hours** prior to appointment date, failure to do so will result in a **cancelation fee of $25.00**

Patients who **miss their appointments** will be applied a **fee of $50.00 for appointments of an hour duration**.

For **missed appointments greater than an hour** the fee applied **will be determined by the provider** based on time/procedures scheduled for that appointment.

Financial/Payment/Insurance Policy

Payment is due at the time of services rendered.

Although we are out of network providers we do submit the claims to your insurance company and they reimburse the patient based on their insurance coverage.

Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

Forms of payment: cash, all credit cards are accepted, personal check and third party financing (Lending Club, Care Credit if approved). Any returned checks will be assessed a $25.00 fee.

Late payments: greater than 90 days overdue will be assessed a monthly finance charge of 1.5 % thereafter.

Outstanding balances: greater than 180 days overdue will be sent to collection.

We advise that you please contact us with any financial concerns so we can work with you and address them as soon as possible.

Consent for Photography

Our dental providers take photographs as a tool to enhance the understanding of your dental health and possible need for treatment. Do you consent to have photographs taken? ☐ Yes ☐ No Signature_____

Consent for use and Disclosure of Health Information

Section A: PATIENT GIVING CONSENT

Name: _____ SSN: _____
Address: _____ Telephone: _____

Section B: TO THE PATIENT, PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: before signing this form, you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, via phone, fax, email, and mail.

Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practice as described in our notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Private Practices, including any revisions of our Notice, at any time by contacting: Dr. Flavio H. Rasetto Telephone**:** (301) 652- 9717 **Address:** 5454 Wisconsin Ave., Suite 1500. Chevy Chase, MD 20815
Right to Revoke: You will always have the right to revoke this consent at any time by giving us written of your revocation submitted to the Contact Person listed above. Please understand revocations of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, _____, have had full opportunity to read and consider the contents of this Consent form and your notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Flavio H. Rasetto DDS, MS
Diplomate American Board of Prosthodontics

J. Steven Kahan DDS
General Dentist

John Tran DDS, MS
Prosthodontist

Chevy Chase Cosmetic & Implant Dentistry
5454 Wisconsin Ave, Suite 1500
Chevy Chase, MD 20815-6922

Phone: 301-652-9717
301-656-6708
Fax: 301-652-2710

drrasetto@cccid.net
drkahan@cccid.net
drtran@cccid.net

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____