



**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:** \_\_\_\_\_

I agree to receive notifications/reminders by phone  I do NOT agree to receive notifications/reminders by phone

**Address:** \_\_\_\_\_

Street City State Zip Code

**E-mail:** \_\_\_\_\_

I agree to receive correspondences/notifications/reminders by email

I do NOT agree to receive correspondences/notifications/reminders by email

**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 (Fill in OR we can scan your card)**

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 \_\_\_\_\_

Do you have any additional insurance (secondary)?  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: \_\_\_\_\_

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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Jaw Joint Pain             | <input type="checkbox"/> Impaired Eyesight / Glaucoma             |
| <input type="checkbox"/> Arthritis / Gout           | <input type="checkbox"/> Hearing Aid / Hearing Disorder           |
| <input type="checkbox"/> Venereal Disease           | <input type="checkbox"/> Kidney Condition: Shunt / Dialysis       |
| <input type="checkbox"/> Epilepsy / Seizures        | <input type="checkbox"/> Frequent Mouth Sores or Lesions          |
| <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Positive HIV; AIDS; AIDS related complex |
| <input type="checkbox"/> Osteoporosis/Osteopenia    | <input type="checkbox"/> Autoimmune disorder                      |
| <input type="checkbox"/> Organ Transplant           | <input type="checkbox"/> Parkinson's Disease                      |
| <input type="checkbox"/> Depression / Anxiety       | <input type="checkbox"/> Drug / Alcohol Addiction                 |
| <input type="checkbox"/> Severe Headaches/Migraines | <input type="checkbox"/> Steroid (prednisone cortisone) Therapy   |
| <input type="checkbox"/> 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

**Endocrine:**

- Thyroid Disease
- Diabetes  
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:**

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

**Respiratory:**

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic Lung Disease          | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Ever Exposed to TB                 |
| <input type="checkbox"/> Hay Fever / Allergies         | <input type="checkbox"/> Persistent Cough or Cough up Blood |
| <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Chronic Sinus problems             |
| <input type="checkbox"/> <b>Current</b> 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? Yes No

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

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Cancellation/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 **cancellation 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.*

**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.



CHEVY CHASE  
COSMETIC & IMPLANT  
DENTISTRY

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

**Dr. J. Steven Kahan DDS**  
General Dentistry

**Dr. John D. Tran DDS, MS**  
Prosthodontist

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.

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: \_\_\_\_\_

**If/When applicable:**

**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: \_\_\_\_\_