Kanwarjit Brar D.D.S., P.C.
PENINSULA DENTAL CENTER
1101 Healthway Dr., Salisbury, MD 21804 410-546-6105 Account # ______________________

Patient Information

Name____ ____________________ Sex M/F________
First MI Last Nickname

Address____
(Mailing Address) City State Zip

Phone__________________________ ______________________________ ______________________________
Home Work Cell

Date of Birth ______________________SSN ___________________ E-Mail Address_________________________________
(MM/DD/YYYY)

Patient Employed by _______________________________________ Occupation ____________________________________

Spouse Information

Name____ ____________________ Sex M/F_______
First MI Last Name Nickname

Phone (Cell)_________________________ Date of Birth ___________________________SSN ___________________________

Insurance Information

Name____ Date of Birth________________ SSN________________
(Policy Holder) First MI Last (MM/DD/YYYY)

________________ ________________ Address____
Relationship to patient Telephone (Street) City State Zip

_____________________________________ _______________________ _________________________ ____________
Dental Insurance Company Name Telephone Number Member ID Is the insurance Through employer? Y/N

__________________________________ ________________________ _____________________ ___________________
Employer Occupation Phone Number Group Number

Responsible Party

Name____ ____________________ Sex M/F________
First MI Last Nickname

________________ Address____
Relationship to patient (Street) City State Zip

Phone__________________________ ______________________________ ______________________________
Home Work Cell

Date of Birth______________________________ SSN__________________________
(MM/DD/YYYY)

Emergency Contact (In case of an Emergency, who may we contact?)

_________________________________ ______________________________ __________________________
First and Last Name Telephone Number Relationship to Patient

I (we) the undersigned authorize treatment by the doctor and supporting staff members.
I (we) understand there may be a **minimum charge of $50.00 for broken appointments without 24 hours notice.**
I (we) understand that if the balance due is not paid before seen I can be refused to be seen **and** incur further charges for having to cancel.
I (we) authorize assignment of insurance benefits where applicable. If payment has not been received from the insurance company within (4) weeks from the date of service, I will accept full responsibility for payment in full within (30) days of notice.
I (we) assume full responsibility for balance of charges not covered by insurance company and agree to pay my estimated portion of charge at the time services are rendered.
I (we) accept full responsibility for any legal or collection agency fees should my account become delinquent.
I (we) understand there will be a 1 1/2% finance charge added to my account if it becomes delinquent.
I (we) understand that patients under the age of 18 years old must be accompanied by a parent or legal guardian.

Patient's Signature____Date________________________

Parent's Signature____Date________________________

PLEASE NOTE: Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, please ask us. We are happy to help. Our office is committed to meeting the standards of infection control of OSHA, CDC, & ADA.

Medical History

Name of Physician_______________________________________Phone___________________________

Last Physical Exam_____________________ Are you under medical treatment now? Y/N Reason________________________

Are you taking any medications for Osteoporosis? _____________________________________

(Females)Are you pregnant or think you may be pregnant? _________ If so how far along? ______________________________

Do you need to pre-medicate for dental procedures? ____

Do you have any mental health conditions? Y/N If yes, what ____

List all Medications, Prescriptions, Vitamins, and OTC (Over The Counter) products you are taking

Name/Strength	Dose	HowOften	Treatment for…	Name/Strength	Dose	HowOften	Treatment for…

List all Surgeries	**Date**	**Surgeries**	**Date**	**Surgeries**	**Date**

Have you ever had any of the following diseases or medical conditions?

Abnormal Blood Pressure	Y	N	Blood Transfusion	Y	N	Hepatitis/Type________	Y	N
Radiation Treatment	Y	N	Heart Condition	Y	N	Tuberculosis	Y	N
Chemotherapy	Y	N	Heart Murmur	Y	N	Anemia	Y	N
Diabetes	Y	N	Pacemaker	Y	N	Hemophilia (Abnormal Bleeding)	Y	N
Epilepsy/Seizures	Y	N	Mitral Valve Prolapse	Y	N	HIV/AIDS	Y	N
Asthma	Y	N	Artificial Heart Valves	Y	N	MRSA	Y	N
Arthritis	Y	N	Artificial Bones/Joints	Y	N	Nervous Disorder	Y	N
Rheumatic Fever	Y	N	Hearing Impairment	Y	N	Vision Impairment	Y	N

Other ____

Do you have an addiction to (Please circle): Drugs/Alcohol/Pills/Huffing/Other ____________________________________

Are you allergic or sensitive to any of the following drugs or materials?

Penicillin	Y	N	Erythromycin	Y	N	Sulfa Drugs	Y	N	Other ____________
Tetracycline	Y	N	Codeine	Y	N	Dental Anesthetics	Y	N	Other____________
Aspirin	Y	N	Latex	Y	N	Clindamycin	Y	N	Other____________

Dental History

Last Dental Visit _______________________Services Rendered ______________________________________

Date of last panoramic or full mouth x-ray ____

How often do you brush your teeth _________________________________ Floss ___________________________

Do your gums bleed ______________ When ____

Are you sensitive to Hot/Cold/Sweet/Pressure ? ____

How were you referred to our office? ____

Are you having a specific dental issue	Y	N	* If yes, explain __________________________________			
Do you smoke	Y	N	* If yes, How much _______________________________			
Frequent Headaches	Y	N	Tired Jaws	Y	N	
Are you pleased with the appearance of your teeth	Y	N	Do you have removable full or partial dentures	Y	N	
Have you ever been treated by a Preiodontist (gum specialist)	Y	N	Have you ever been treated by an Orthodontist (braces)	Y	N	
			Do you have any TMJ issues	Y	N	
Do you chew ice	Y	N	Do you grind your teeth	Y	N	

Patient Signature ____ **Date** ______________________________

(parent or guardian if minor)

Peninsula Dental Center, PC
1101 Healthway Drive
Salisbury, Maryland 21804
1(410) 546-6105

Kanwarjit Brar, DDS
Account #__________

Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service.

As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.

If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.

Insurance is a patient's benefit designed to assist the patient in their financial obligation to the office of Peninsula Dental Center, PC. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of Peninsula Dental Center, PC.

The office will collect the patient's deductible and the estimated co-payment at the time of service. After the primary insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied towards future treatment.

In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless a signed financial agreement has been approved.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles along with any procedures that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any insurance claims not paid within 60 days of service.

I am aware that there is a broken appointment policy. If I do not give 24 hours notice to cancel or change my appointment, there is a minimum charge of $50.00. **FOR SATURDAY APPOINTMENTS THERE IS A $150.00 CHARGE IF I DO NOT GIVE A WEEK'S NOTICE (7 days).**

____ ________________________

Print and **Sign** Patient Name (parent if minor) or Responsible Party Date