PATIENT INFORMATION

Name Last________________ First ________________ M.I.______ Sex: M/ F

Patient Address ________________ Apt # ____ Birth date ________ Marital Status ______

City ________________ State ______ Zip ________ Social Security #: ________________

Home Phone ________________ Work Phone ________________ Cell Phone ________________

Employer ________________ Occupation ________________ No. Years Employed ________

Who may we thank for referring you to our office? ________________ Reason for visit ________________

RESPONSIBLE PARTY INFORMATION

NAME Last________________ First ________________ M.I.______ Marital Status ______

RESIDENCE Street________________ Apt.#______ City________________ State______ Zip________

MAILING ADDRESS Street________________ Apt#______ City ________________ State ______ Zip ________

How long at address ____ HOME PHONE ________________ WORK PHONE________________ CELL PHONE________________

Social Security # ________________ Birthdate ________ Driver's License # ________________ Relation to Patient ______

Employer ________________ Occupation ________________ No. Years Employed ________

Responsible Party's Spouse

Name________________________________
Last First Middle

Employer________________ No. of years employed________

Occupation________________ Soc. Sec. # ________________

Work Phone ________________ Birthdate ________________

Emergency Information: Relative NOT living with you

Name ________________ Relationship ________

Address ________________________________

City, State ________________ Phone ________

Dental Insurance Information (Primary Carrier)

Insured's Name ________________________________

Insurance Company ________________________________

Insurance Co. Address ________________________________

Insured's Employer ________________________________

Insured's Soc. Sec. #________________ Group # ________________

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name ________________________________

Insurance Company ________________________________

Insurance Co. Address ________________________________

Insured's Employer ________________________________

Insured's Soc. Sec. # ________________ Group # ________________

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is Strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
Are you having ***problems*** now?		
What?		
Is your present dental health ***poor***?		
Do you wear ***dentures***?(Partials or Full)		
Are you ***unhappy*** with your dentures?		
Would you like to know more about ***permanent replacements?***		
Are you ***apprehensive*** about dental treatment?		
Have you ever had any ***periodontal (gum)*** treatments?		
Do your gums ***Bleed***, or feel ***Tender*** or ***Irritated***?		
Are your teeth ***sensitive*** to hot, cold, sweets, pressure?(circle)		
Are you ***unhappy*** with the ***appearance*** of your teeth?		
Are you aware of *grinding* or ***clenching*** your teeth?		
Do you have ***headaches, earaches or neck pains***?		
Have your worn ***braces*** on your teeth (***orthodontics***)?		
Do you have ***discolored*** teeth that bother you?		
Would you like your smile to *look better* or ***different***?		
Do you ***regularly*** use ***dental floss***?		

How long since you have seen a dentist? ________________

Last ***Complete*** Dental Exam, Date: ________________

Last ***Full Mouth X-rays***, Date: ________________

Name of previous dentist: ________________

City: ________________ State ________________

How do you feel about your teeth? ________________

____

Please RANK the following in the order in which they would keep you from having dental treatment.

FEAR of pain # LACK of concern #
COST of treatment # MISSING work time #

~~ PLEASE COMPLETE OTHER SIDE ~~

Kurt B. Linkoff, DDS, PA

1445 LIBERTY ROAD | ELDERSBURG MD, 21784 | (410) 795-2900

Written Financial Policy

Thank you for choosing Kurt B. Linkoff, DDS, PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

  We offer a 4% cash/check, 2% credit card% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Kurt B. Linkoff, DDS, PA charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

[1] Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Kurt B. Linkoff, D.D.S.
1445 Liberty Road
Eldersburg Maryland 21784
410-795-2900

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print Name: ____

Signature: ______________________________ Date: ________________
(Patient, parent or legal guardian)
If signed by patient representative, state relationship to patient______________

MEDICAL HISTORY	YES	NO
Do you have any ***Current Health Problems?***		
Are you under a ***Physician's Care*** now?		
For what?		
What ***Medications*** are you currently taking?		
Are you ***Pregnant?***		
Do you use ***cigars/cigarettes, pipe*** or ***chewing tobacco***(circle)		

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease	AIDS/ARC/HIV Positive	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Hepatitis C	Asthma
Rheumatic Fever	Liver Disease	Hay Fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia (Bleeding Problem)	Diabetes
Heart Pacemaker	Fever Blisters	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints
Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Alcoholism
Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Nitrous Oxide	Local Anesthetic Codeine	Erythromycin Penicillin	Latex(balloons, gloves, etc)

Are you aware of being allergic to any other medications or substances? ____________________

Is there any other Medical or Dental information that you feel I should know about? ____________________

Family Physician ____________________ Phone number ____________________

Please read the following and sign:

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

____________________ Date:__________ DENTIST Signature ____________________

PATIENT Signature
(If minor, Parent or Guardian Signature)

This contract is to be construed pursuant to the Laws of the State of Maryland and Patient consents to the Jurisdiction of the Courts of the State of Maryland. In the event of Patient's default in the performance of his/her obligations under this agreement Dr. Kurt Linkoff, D.D.S., P.A., shall be entitled to recover the full contract amount provided for herein as liquidated damages and in addition to Dr. Kurt Linkoff, D.D.S., P.A. shall be entitled to reasonable attorney's fees, court costs and litigation expenses.

____________________ Date __________

Signature of Person/s responsible for account

Staff Member Initials __________