

**Cosmetic Dental Center  
4 Reservoir Circle Suite 100  
Baltimore, Maryland 21208  
410-486-5678 phone 410-486-5719 fax  
www.ddsbaltime.com**

Welcome to our practice! We are truly delighted that you have selected our office to care for your dental needs. We will make every effort to see that your dental visit is as comfortable as possible. We are very sensitive to the feelings of our patients and encourage open communication.

At your first visit, the doctor will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, oral cancer screening, periodontal health evaluation which will include examination of your teeth and soft tissue and study models (if needed). The doctor will listen carefully to your dental concerns and answer any questions that you may have. Please bring your latest full mouth series of x-rays with you to this visit. If you do not have a current full mouth series, one will be taken at this visit. Following this exam, the dentist will discuss their findings, develop a treatment plan that you are comfortable with and be scheduled according to your personal needs.

Please come prepared for your appointment by printing and completing new patient registration forms. If you have dental insurance, be sure to provide all requested information to assist us in the benefit verification. Payment is expected at the time of visit, including your co-pay if you are covered by dental insurance. As a courtesy, we will file claims on your behalf with your dental insurance company. If you would like to finance your dental expenses, we participate with Care Credit and can give you the necessary forms if you are interested in applying.

Unless an emergency comes up, you can expect us to be on time. We ask that you make every effort to keep your scheduled appointments. Missing appointments disrupts sequencing of care and delays completion of your treatment. Please call at least 24 hours in advance if you need to reschedule your appointment.

We appreciate the confidence that you have shown in us and look forward to meeting you! Please call with any questions.

Sincerely,

Dr. Anna M. Finkler  
Dr. Larry A. Layton  
Dr. Mark Briner

**Cosmetic Dental Center**  
**4 Reservoir Circle Suite 100**  
**Baltimore, Maryland 21208**  
*HIPAA Privacy Policy*

**NOTICE OF PRIVACY PRACTICES**

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.**

**OUR LEGAL DUTY**

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 23, 2015, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our Notice in our office. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We may use and disclose health information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use or disclose your health information to another dentist or health care provider providing treatment to you, or if we refer you to another health care provider.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure. This may be done electronically or by mail.

**Health Care Operations:** We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

**To Your Family, Friends, and Other Persons Involved in Your Care:** We may share with a family member, friend, or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

**Use and Disclosure of Health Information Required by Law:** We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state workers' compensation laws.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Contacting You:** We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

**Health-Related Services:** We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

**Your Authorization:** As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

## PATIENT RIGHTS

**Right to See and Copy Your Health Information:** You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request to us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

**Right to Accounting of Disclosures of Your Health Information:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and health care operations, and certain other activities for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 4 Reservoir Circle Suite 100 Baltimore, MD 21208.

**Right to Request Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 4 Reservoir Circle Suite 100, Baltimore., MD 21208. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

**Right to Request Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 4 Reservoir Circle Suite 100 Baltimore, MD 21208.

**Right to Request Amendment:** You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer 4 Reservoir Circle Suite 100 Baltimore, MD 21208. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

**Right to Written Notice:** If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

## PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer

4 Reservoir Circle

Suite 100

Baltimore, MD 21208.

410-486-5678

**Cosmetic Dental Center of Maryland  
4 Reservoir Circle Suite 100  
Baltimore, Maryland 21208  
410-486-5678**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**Patient Giving Consent:**

Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Patient: Please read the following statements carefully:**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**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 healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice 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 Privacy Practices (HIPPA Privacy policy) including revisions of our notice at any time by contacting:

Front office of Cosmetic Dental Center at the address or phone number above

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to front office of Cosmetic Dental Center. Please understand that revocation 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 continue treating you if you revoke this consent.

**SIGNATURE**

I have had the opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. 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.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representatives Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

Include completed consent in patient's chart

**COSMETIC DENTAL CENTER  
4 Reservoir Circle Suite 100  
Baltimore, Maryland 21208  
410-486-5678, 410-484-5800**

## **DENTAL INFORMED CONSENT FORM**

We at The Cosmetic Dental Center would like all of our patients to have knowledge of risks and benefits of the dental procedures performed by our facility. We ask that you review the procedures listed below and feel free to ask any questions. If one of these procedures is a part of your prescribed treatment, a customized treatment plan including **estimated** fees and treatment specifics will be presented to you for your review and signature at the time treatment is recommended.

**1. Dental X-Rays and Comprehensive Exam:** All new patients are required to have a full mouth set of X-Rays (18 radiographs) and a comprehensive exam by the doctor prior to any prescribed treatment. It has been recommended that all patients have routine diagnostic radiographs based on the American Dental Association's guidelines (a full mouth series every 3-5 years and bitewings every year). It is imperative that patients understand that the radiographs are necessary for the dentist to diagnose and treat possible decay (cavities), infection, fractured teeth, bone loss due to gum disease, and tumors. Without periodic radiographs, the dentist cannot identify and disclose potential problems, which could lead to serious jaw infections, tooth loss, and bone destruction leading to potential jaw fractures. No other reasonable option to dental radiographs exists at this time.

**2. Dental Prophylaxis:** A dental procedure that is performed primarily to help reduce the risk of gum and tooth disease. Also known simply as a *prophy or cleaning*, this dental procedure is recommended to be performed every six months or sooner, depending on the patient's history. It is completed by a licensed dentist or licensed dental hygienist who has received specialized training in dental care. During a dental prophylaxis, your dentist/hygienist performs both scaling and polishing. During the scaling process, dental tools are used to remove tartar, plaque, and stains from the teeth – including beneath the gum line. The polishing process smoothes your teeth removing rough spots which might otherwise attract bacteria. During a dental prophylaxis, your dentist will also inspect your teeth and jaw for any obvious signs of ill health. This inspection may reveal underlying medical issues such as receding gums, erupting wisdom teeth, dental cavities, or even oral cancer – some of which will require immediate treatment. Early identification of dental problems can help you deal with them before they become serious.

**3. Dental Probing:** A periodontal examination and probing are used to assess the health of your gums and teeth. They can help your dentist diagnose the gum diseases gingivitis and periodontitis. They also can reveal receding gums, exposed roots, tooth grinding (bruxism) and other problems. The exam and probing include taking measurements of the spaces between your teeth and gums. Any dentist or dental hygienist can measure these gaps. If your dentist has concerns about your gum health, you may be referred to a periodontist. This is a gum-disease specialist. This specialist will take measurements during your first visit. The ADA recommends that probing depths are measured once a year to maintain periodontal health. Some dental insurance may not cover these measurements and the patient will be held responsible for the \$20 fee associated with this procedure.

4. **Drugs and Medications:** Antibiotics and analgesics as well as other medications are prescribed by the dentist for treatment of various conditions. These drugs can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.) Local anesthetics are used daily for routine dental treatment. Risk of local anesthesia may include temporary or permanent numbness or bruising and irritations or redness at injection site. It is imperative for the patient to know their list of prescribed medications and allergies and inform the dentist of any prior allergic reactions.

5. **Changes during the course of treatment:** During treatment it may be necessary to change or add procedures due to underlying conditions or complications. The dentist will disclose these complications to the patient and inform the patient on the best course of action.

6. **Sedative Fillings:** Sedative fillings are medicated temporary fillings used to treat sensitive teeth with restorations close to the nerve. If the tooth becomes symptomatic after 4-6 weeks, it is likely the tooth will need further treatment, such as a root canal. If the tooth is asymptomatic after 4-6 weeks, then a permanent filling can replace the sedative filling. The sedative filling allows the tooth to form reparative dentin and enable the Doctor to remove decay and restore the tooth.

7. **Fillings and Crowns:** Any time a tooth is subjected to drilling, some healthy tooth structure is removed with the diseased tooth structure. Despite copious irrigation, the heat and vibration of the drill irritate the nerve endings inside the tooth. It is possible that as a result of dental fillings and crowns, root canal treatment may be necessary. When restoring teeth with porcelain or composite restorations, it is not always possible to match the color of natural teeth exactly and sometimes require trips to the lab for custom shading and staining. Temporary crowns used during course of treatment, are made out of a plastic material and use temporary cements to retain the crown in place, therefore, the temporaries may break and come off unexpectedly. You will need to be careful to ensure that they are kept in place until the permanent crowns are delivered. The final opportunity to make changes to new crowns and/or bridge (including shape, size, or color) must be done at the crown delivery appointment.

**General treatment risks:** I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, hot sensitivity, biting sensitivity, abscess, and pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration, root canal treatment and in rare cases tooth removal.

I have carefully read the general consent above and fully understand all risks as it relates to my possible treatment options. I understand that once my personalized treatment is prescribed, I will receive a customized consent to review and sign as it pertains to my individual needs and circumstances.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Date of last physical \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone : \_\_\_\_\_

In the last five years, have you been: (if yes, please explain)

- a. Hospitalized?  Yes  No \_\_\_\_\_
- b. Had a serious illness?  Yes  No \_\_\_\_\_
- c. Had a major operation?  Yes  No \_\_\_\_\_

Have you ever been told to take antibiotics before dental visits?  Yes  No

Please list all medications (prescription, over the counter or herbal) that you are currently taking?  
(Include birth control medications and daily aspirin therapy if applicable)

Have you had an **allergic** or unusual reaction to any of the following?

- |                          |  |                   |  |
|--------------------------|--|-------------------|--|
| Dental local anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin        | <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Ibuprofen (Advil)        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex             | <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Acetaminophen (Tylenol)  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metals            | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Codeine                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Other Allergies          | _____  |                   |  |

Indicate which of the following you have had, or have at present. Please mark "Yes" or "No" to each item.

Heart <input type="checkbox"/> surgery <input type="checkbox"/> disease <input type="checkbox"/> attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever/Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure	<input type="checkbox"/> High <input type="checkbox"/> Low	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease/Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints (hip, knee etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous/ Anxious	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer list type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Females only:	
Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use:	<input type="checkbox"/> (circle) <input type="checkbox"/> No Chew Smoke	Are you pregnant? How many weeks _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive or prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taking Bisphosphonates	<input type="checkbox"/> Yes <input type="checkbox"/> No	Being treated for Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If you answered yes to any item above, please explain;

Any other problem, condition or disease not listed? Please explain;

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, or changes to my medical history occur, I will notify this office of such changes.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Welcome! So we may provide you with the best possible care, please complete both sides of this medical/dental history form  
All information will be kept confidential

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last full mouth x-rays \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? Please circle

Mouthwash Water jet device Fluoride supplements Interdental stimulators

Other; please list \_\_\_\_\_

Do you have any dental problems now?  Yes  No

If yes, please describe: \_\_\_\_\_

Are your teeth sensitive to:

Hot foods or liquids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold foods or liquids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biting or chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sweet/ Sour foods or liquids	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had or noticed:

Mouth odor/bad tastes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired jaws, especially the morning	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding or Aching gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose /broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in bite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snore or other sleep disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tooth Decay	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grind teeth while awake or asleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth breathing <input type="checkbox"/> awake <input type="checkbox"/> asleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain (joint, ear or side of face)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Impaction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty chewing on either side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head, neck or shoulder aches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores , lumps, lesions or swelling of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty opening or closing of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gag Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bite lips or cheek fingernails regularly	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking or Popping of the jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had:

Oral surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Partials	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bite plate / mouth guard	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding following extractions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Serious injury to the mouth or head	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been told to take a pre-medication prior to dental treatment?  Yes  No

Is there anything else that you would like us to know regarding your previous dental treatment?  Yes  No  
If yes, please describe:

Doctor's Notes:



**Cosmetic Dental Center  
4 Reservoir Circle Suite 100  
Baltimore, Maryland 21208  
410-486-5678 phone 410-486-5719 fax  
baltimoredentists@ddsaltimore.com**

FINANCIAL POLICY

If you have dental insurance, we will be more than happy to submit all insurance forms for you and help you recover the most from your benefits. As a courtesy, we will help determine your estimated co-pay. That estimate is due at the time of service. Any remaining balance after your insurance has paid is your responsibility.

We will do everything we can to help you to afford the treatment that you need and want. Forms of payment accepted include cash, check, major credit cards as well as Care Credit, BeWell and Lending Club Financing.

It is understood that I, or we, will be responsible for all charges for present and future services incurred on this account, regardless of any insurance coverage that I might have. Broken and/ or cancelled appointments without 24 hour notice are subject to a \$75 fee. In the event of non payment, I agree to pay all costs of collections, including fees for returned checks, attorney fees of 1/3 of all sums collected, court costs, pre-judgment interest, any failed appointment charges and broken appointment fees as well as interest on the account at 18% per annum.

GUARANTOR'S SIGNATURE \_\_\_\_\_(SEAL)

DATE \_\_\_\_\_