Physician Name_____ **Phone #**_____

Pharmacy Name_____ **Phone #**_____

Y	N	Conditions
☐	☐	Abnormal bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Condition
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Transplant Surgeries
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other:

_____

_____

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height _____

Weight_____

If female, please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If yes, # of weeks ____
☐	☐	Are you nursing?

Medications: Please list all

Y	N	
☐	☐	**Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below**

_____ _____

Signature **Date**

Drs. Meson and Azoulay
8383 Cherry Lane
Laurel, Maryland 20707
301-498-5320

Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fees for treatment, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and preserve our relationship.

Payment for services is due at the time treatment is rendered. If you have dental insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. We will be happy to process your **primary** insurance claims for reimbursement as well as accept insurance assignment. We will gladly discuss your proposed treatment and answer general questions relating to your insurance. Our office is provided with "general benefit" information from your insurance, which is not specific or a guarantee of benefits or payments. If for any reason your insurance, traditional or PPO, denies a claim for services that *they* feel are unnecessary, you will be responsible for the balance. Please refer to your benefits booklet for specific information. You must, however, understand that:

Your deductible if any and "estimated co-payment" are collected at the time of service. We can not guarantee exact amounts to be paid by your insurance carrier. If there is any remaining balance after your insurance has processed your claim, we will forward a balance statement to you. Statements sent are due upon receipt and unpaid balances over 60 days will be subject to finance charges in the amount of 1.5% per month.

We render treatment we feel is in the best interest of the patient, not your insurance company. If you have questions regarding specific procedures, contact your insurance company directly or feel free to ask us to send a pre-authorization to your dental insurance. This process generally takes 4-6 weeks and must be received prior to treatment being rendered.

Missed and broken appointments waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste there will be a charge of $35 for each 30 minutes of appointment time. We strictly enforce this policy so please take time to carefully select your appointment times. A broken appointment is classified as the failure to appear for an appointment, cancellations not made 48 hours in advance or lateness that results in an inability to complete scheduled treatment.

If we receive returned checks due to insufficient funds or closed accounts you will be charged $35.

Please understand that if for any reason your account must be placed in the hands of a third party for collections, your account will be charged 1/3 of the total balance for collections fees.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Signature of Patient or Parent Responsible if Minor Date