New Patient Information

Montpelier Family Dentistry
David Koilpillai, DDS

Welcome to our practice.
Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number ___________

Today's date _______________

First name ______________________ Middle initial _____ Last name ______________________

I prefer to be called (nickname, etc.) ______________________ ☐ Male ☐ Female

Address ______________________ City ______________________ State _______ ZIP _______

Date of birth ______________________ Social security no. ______________________

Home phone (___) _____-______ Work phone (___) _____-______ Cell phone (___) _____-______

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call ______________

Fax (___) _____-______ E-mail ______________________ Driver's license no. ______________

Employer ______________________ Occupation ______________________

Spouse's name ______________________ Spouse's employer ______________________

Whom may we thank for referring you? ______________________

If the patient is a child

School ______________________ School phone (___) _____-______ Grade ___________

Dental History

Reason for today's visit ______________________

Are you currently in pain? ☐ Yes ☐ No
If so, please describe: ______________________

Do you have any dental problems now? ☐ Yes ☐ No
If so, please describe: ______________________

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No
If so, please describe: ______________________

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _______________ Date of last cleaning _______________ Date of last full mouth X-rays _______________

Procedure(s) done at last dental visit ______________________

Previous dentist's name ______________________

City ______________________ State ___________ Phone (___) _____-______

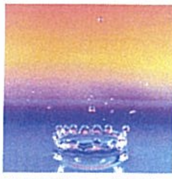
Why are you changing dentists? ______________________

How often do you have dental examinations? _______________ How often do you brush your teeth? _______________

How often do you floss? _______________ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) ______________________

Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
Do you have frequent headaches? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No
Are your teeth sensitive to heat/cold? ☐ Yes ☐ No
Do you still have your wisdom teeth? ☐ Yes ☐ No



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Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe ____________________

____

Is there anything else about your past dental treatment(s) that you would like us to know? ____________________

____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? ____________________

Hospital or Physician's name ____________________ Phone ____________________

Hospital or Physician's City ____________________ State ____________________

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain ____________________

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? ____________________

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? ____________________

Do you use tobacco? ☐ Yes ☐ No **Do you use alcohol or any other controlled substance?** ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No			

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric/		
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No
Artificial Bones/Joints	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart (Surgery, Disease,			Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Attack)	☐ Yes	☐ No	Shingles/Chicken Pox	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Sickle Cell Disease/Traits	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Hemophilia/Abnormal			Snoring/Sleep Apnea	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Stomach Problems/ Ulcers	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Hospitalized for Any Reason	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease/STD	☐ Yes	☐ No

Please list any serious medical condition(s) that you have ever had not listed above:

____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other ____________		

Patient signature____________________

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Montpelier Family Dentistry
David Koilpillai, DDS

Dental Insurance

Primary Carrier

Insurance co. name ______________________ Insurance co. phone ______________________

Address (Street, City, State, ZIP) ______________________

Group no. (Plan or Policy no.) ______________________ Insured's I.D. no. ______________________

Insured's name ______________________ Relationship to patient ______________________

Date of birth ______________________ Insured's social security no. ______________________

Insured's employer name ______________________ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name ______________________ Insurance co. phone ______________________

Address (Street, City, State, ZIP) ______________________

Group no. (Plan or Policy no.) ______________________ Insured's I.D. no. ______________________

Insured's name ______________________ Relationship to patient ______________________

Date of birth ______________________ Insured's social security no. ______________________

Insured's employer name ______________________ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name ______________________ Relationship to patient ______________________

Social security no. ______________________ Phone (____) ______ - ______

Driver's license no. ______________________ Date of birth ______________________

Address (Street, City, State, ZIP) ______________________

Employer ______________________ Work phone (____) ______ - ______

Preferred payment method: ☐ Cash ☐ Credit Card ☐ Check

Visa/MC/AMEX no. ______________________ Exp. date ______________________

If patient is a minor, name of parent or legal guardian and relationship ______________________

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

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Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand 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, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature ______________________ *Date* ______________________

Person to contact in case of emergency

Name ______________________ Relationship ______________________

City ______________________ State__________ Cell phone ______________________

Home phone ______________________ Work phone ______________________

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date ______________________ Initials ______________________

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 IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state 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 (04-01-03) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such chances are permitted by applicable law. We reserve the right to make the change in our privacy practices and the new terms of our notice effective for all health information we maintain, including health information we created or received before we make the changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request.

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 us using information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations, i.e…
Treatment. We may use or disclose your health information to a physician or other healthcare provider who provides treatment to you.
PAYMENT. We may use and disclose your health information to obtain payment for services we provide to you.
HEALTHCARE OPERATIONS. We may use and disclose your health information in connection with your healthcare operations, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credentialing activities.
YOUR AUTHORIZATION. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this notice.
TO YOUR FAMILY AND FRIENDS. We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for you healthcare, but only if you agree that we do so and designate this person on the form attached to this notice.
PERSONS INVLOVED IN CARE. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, general condition or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that directly relevant to the persons involvement.

David D. Koilpillai, DDS

Montpelier Family Dentistry
14502 Greenview Drive Suite 100
Laurel, MD 20708

Telephone: 301-604-0025
Fax: 240-554-0329

Acknowledgement of Receipt of
Notice of Privacy Practices

By signing this form, you acknowledge that this Dental Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPPA, the new federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Dental Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

____
Patient's Signature or Guardian

____
Date Signed

Provider Use Only
If the patient was not able to sign due to an emergency, or did not want to sign, please document if the patient was given the notice and the reason why the patient did not sign below.

Patient was given notice: ____ Yes ___ No

Reason signature was not obtained:
____
____
____

_______________________________ _______________________
Staff Signature Date

Montpelier Family Dentistry

14502 Greenview Drive, Suite100 Laurel, MD 20708 (301)604-0025

Written Financial Policy

Thank you for choosing Montpelier Family Dentistry for your dental services. 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, Debit card, Visa, MasterCard, Discover

After the patient has come in for an initial visit and a comprehensive treatment plan has been presented, we offer a 5% courtesy discount to patients who prepay for their **entire** treatment plan in full with cash or check. (**Discount does not apply to any insurance plans or any third party financing- ex: Care Credit, Lending Club, etc).**

• NO INTEREST Payment Plans thru: Care Credit, Spring Stone

  - Allow you to pay overtime with NO INTEREST
  - Convenient, low monthly payment plans also available
  - No annual fees or pre-payment penalties

Please note:

Montpelier Family Dentistry **requires payment prior to scheduling for your treatment**. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. (Note what is estimated by your insurance to be covered is **ONLY** an **ESTIMATE**). **Services which are NOT COVERED will be the responsibility of the patient.**

A fee of $55.00 is charged for patients who miss or cancel appointments without 24- hour notice.

If an outstanding balance/bill is not paid within 30 calendar days, a finance charge will be applied.

Montpelier Family Dentistry **charges $35.00 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.

For any future scheduled appointment, a deposit/copayment is required to ensure that the time and space is reserved for you.

I have read the above policy and agree to accept ALL financial responsibility

Patient, Parent or Guardian Signature ______ Date ______

Patient Name (please Print) ______