Patient Registration

Patient Information

PATIENT NAME (First, MIddle, Last) | **DATE OF BIRTH** | **PRIMARY CARE PROVIDER**

STREET OR MAILING ADDRESS (P.O. Box) | **CITY** | **STATE** | **ZIP CODE**

HOME PHONE | **CELL PHONE** | **WORK PHONE** | **EMAIL ADDRESS** (Required for Patient Portal)

PRIMARY LANGUAGE

PREFERRED CONTACT METHOD (Check all that apply): ☐ Home Address (Letter) ☐ Home Phone ☐ Cell Phone

EMPLOYER

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Active Duty

STUDENT STATUS: ☐ Full Time ☐ Part Time ☐ Not a Student

EMERGENCY CONTACT NAME | **RELATIONSHIP TO PATIENT** | **PHONE** DAYTIME | EVENING

BIRTH SEX
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

CURRENT GENDER
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

SEXUAL ORIENTATION
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, or homosexual
- ☐ Something else (please describe): ____________

MARITAL STATUS
- ☐ Choose not to disclose
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Annulled
- ☐ Widowed
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Life Partner

PREFERRED PRONOUN
- ☐ Choose not to disclose
- ☐ She, Her, Hers
- ☐ He, Him, His
- ☐ Ze, Hir
- ☐ They, Them, Theirs
- ☐ Other: ____________

GENDER IDENTITY
- ☐ Choose not to disclose
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify): ____________

RACE
- ☐ Choose not to disclose
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Other: ____________

ETHNICITY
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other: ____________

Responsible Party

RESPONSIBLE PARTY NAME (First, Middle, Last) | **DATE OF BIRTH** | **EMPLOYER**

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Guardian ☐ Self ☐ Spouse ☐ Other: ____________

ADDRESS | **HOME PHONE** | **WORK PHONE**

SEX: ☐ Male ☐ Female ☐ Undifferentiated

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID# | **GROUP#**

SUBSCRIBER NAME (Policy Holder) | **DATE OF BIRTH**

ADDRESS | **PHONE**

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE CARRIER

INSURANCE ID# | **GROUP#**

SUBSCRIBER NAME (Policy Holder) | **DATE OF BIRTH**

ADDRESS | **PHONE**

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

CONTINUED ON REVERSE

If you are here because of an injury, is it: ☐ **Work Related** ☐ **Auto Related** ☐ **Neither**

All Payment Is Due at Time of Service

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of service. I will be responsible for fees and charges according to Frederick Health Medical Group and my health plan. If I do not provide a **valid** insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Frederick Health Medical Group and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages and/or an automatic dialing device ("auto dialer"), by text message, or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE DATE

RELATIONSHIP TO PATIENT

Health Insurance Portability and Accountability Act (HIPAA)

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Frederick Health Medical Group, have been offered a copy of the Notice of Privacy Practice, which describes my privacy rights in accordance to federal and state requirements.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

Communication Consent

I understand that I may be contacted by Frederick Health/Frederick Health Medical Group and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: ______________________
This communication is to confirm office appointments or leave a message regarding my care.

☐ **No**, please **do not** contact me by the following means: ______________________

I authorize my provider and the appropriate staff to share medical/billing information about my care/account to the following individuals as indicated below

Names	**Relationship(s)**	**Phone #(s)**

It is the patient's responsibility to notify Frederick Health Medical Group of any changes to this form.

PRINT PATIENT'S NAME HOME/CELL PHONE NUMBER (PLEASE CIRCLE ONE)

PATIENT'S DATE OF BIRTH

PATIENT OR LEGALLY RESPONSIBLE PERSON'S SIGNATURE DATE WITNESS DATE

Office Use Only

ENTERED BY DATE

REV. 6/2020

Dental Clinic

Patient Name: ____ **DOB:** _________________

Name/location of your Pharmacy: ____

Date of Last Dental Visit: _______________

Are you Pregnant? YES / NO How many Months: __________________

CURRENT/PAST MEDICAL HISTORY

Anxiety or Depression	Yes	No
Under psychiatric care	Yes	No
Seizure disorder	Yes	No
Migraine headaches	Yes	No
Sleep apnea	Yes	No
Vision or Hearing loss	Yes	No
Weakness	Yes	No
Arthritis	Yes	No
Bone/Joint pain	Yes	No
Acid reflux	Yes	No
Stomach ulcers	Yes	No
Asthma or COPD	Yes	No
Chronic cough	Yes	No
Excessive thirst	Yes	No
Diabetes Type 1 or 2	Yes	No
Taking Insulin	Yes	No
High Cholesterol	Yes	No
Thyroid disease	Yes	No
Hyper / Hypo or other _________________		
Autoimmune disease	Yes	No
Type _______________________________		
Herpes simplex I or II	Yes	No
Hepatitis B or C	Yes	No
HIV or AIDS	Yes	No
Tobacco use	Yes	No
Antibiotic pre-med	Yes	No

Clotting disorder	Yes	No
Anemia	Yes	No
Iron deficiency or other _______________		
High blood pressure	Yes	No
Angina/chest pain	Yes	No
Heart Murmur	Yes	No
Pacemaker or Defibrillator	Yes	No
Heart attack	Yes	No
A-fib	Yes	No
Stroke	Yes	No
Taking blood thinner	Yes	No
Joint replacement	Yes	No
Type/Date __________________________		
Organ transplant	Yes	No
Type/Date __________________________		
Kidney disease	Yes	No
Dialysis	Yes	No
Days of the week ___________________		
Blood transfusion	Yes	No
Cancer	Yes	No
Type ______________________________		
Chemo or Radiation	Yes	No
Currently in treatment	Yes	No
Tuberculosis	Yes	No
Positive PPD	Yes	No
Negative chest x-ray	Yes	No

Recent hospitalizations:

____

____

Please list OTHER conditions not mentioned above:

____

____

ALLERGIES **NO KNOWN ALLERGIES**

Please list any medication allergies:

______________________ ______________________ ____________________

Reaction: ______________ **Reaction:** ______________ **Reaction:** ____________

MEDICATIONS

Name	**Dose**	**Frequency**
____________________	_____________________	____________________
____________________	_____________________	____________________
____________________	_____________________	____________________
____________________	_____________________	____________________
____________________	_____________________	____________________
____________________	_____________________	____________________
____________________	_____________________	____________________
____________________	_____________________	____________________

List **Primary Care Physician** and **Specialists** you see so we may contact **IF** Medical Clearance is needed prior to dental work:

Type	**Physician Name**	**Phone**	**Fax**

Patient Signature: ____ Date: _________________

Appt. Date: ______________________________

APPLICATION FOR THE DENTAL SLIDING FEE SCALE

Patient's Name: ____ **DOB**: __________________

Date of Application: ___________ **Referral Source**: ____________________ **Seeking Surgery Clearance? Y or N**

Reason for Visit: ____

Address: ____ *How long have you lived at this address?*____________

____ *Homeless? Y or N* *Veteran? Y or N*

Telephone number: ____________________

Cell Phone number: ____________________

Occupation: ___________________________

Employer: ____________________________

Pharmacy:________________________________

Reminder to Bring:

- ***Proof of residency of Frederick County***
- ***Proof of income (paper from SSI, last year's tax return, paper from food stamps)***
- ***Photo ID, List of daily medications***
- ***List of any doctors or specialist that you see***

MEDICAL & DENTAL INFORMATION

Primary Care Provider: ____

Are you currently a patient in more than one Frederick Health facility?

Yes _____ No______ *If so, please specify which centers*: ____

Medicare Patient: Yes _______ No_______

Do you currently have any dental insurance? Yes _______ No_______ **(WAIVER NEEDED)** Y / N
***If yes, please complete the following information*:**

Name of Insurance: _______________________________________

Policy holder's name: _______________________________________

Policy number: ________________________ Date of Birth: ________________________

HOUSEHOLD MEMBERS (LIST ONLY THOSE WHO ARE ON YOUR INCOME TAX RETURN)
ALL OTHER MEMBERS IN HOUSEHOLD NEED TO APPLY SEPARATELY

Name **Age**

1. ____________________________________ 4. ____
2. ____________________________________ 5. ____
3. ____________________________________ 6. ____

Additional Dependents: ____________________

INCOME: List ALL Household income from the following sources:

Please provide a copy of your most recent income tax return. If you have a change in financial circumstance since the last income tax return, please provide documentation of current income or financial status.

Total family members: _____

	Total for 12 months
Wages/ Unemployment	_________________
Social Security / Disability	_________________
Public Assistance/ Food Stamps	_________________
Alimony	_________________
Military Pensions / Pensions	_________________
Total	_________________

Changes of Circumstances: Since the date that you last filed your income tax return, has your income changed drastically? Have you had a change in financial circumstances? Please write a detailed note about how your situation has changed.

Patient approved for Category: _____________________

Frederick Health Medical Group designee: ___________________________

D0140 (Limited Exam) $__________ **D0220 (1 PA) $______________**

D0330 (Pano) $ _________ **D0270 (1 BWX) $ _____________**

Total: $_____________

D0150 (Comp Exam) $ _______ **D0220 (1st PA) ________**

D0274 (4 BWX) $__________ **D0230 (5 PA) $ _________**

D1110 (Prophy) $__________ **D0330 (Pano) $ _________**

Total: $___________

We are a teaching environment in partnership with the University of Maryland School of Dentistry and School of Hygiene in efforts to provide students with an educational opportunity in public health. As a patient of Frederick Health Medical Group Dental Clinic, you will be treated by a rotation of senior dental students who are overseen by our dental providers. Due to the demand of adult dental needs in Frederick County, we ask you understand how important it is to confirm your dental visit at least 24 hours prior to your appointment, as we receive calls for dental emergencies every day.

I affirm that the above information is true and correct to the best of my knowledge.

Signature: ________________________________ Relationship to Patient(s) _____________________

Date: _____________________________________

516 Trail Avenue · Frederick, Maryland 21701·Phone: 240-566-7005·Fax: 240-566-700