Richard J. Porac, D.D.S.
Douglas A. Bachtell II, D.D.S.

FAMILY DENTISTRY

1125 DIAMOND DR.
HAGERSTOWN, MD 21740
TELEPHONE: (301) 739-8081
FAX: (301) 739-8082

Section I: **Patient Information** **Date**__________

Name:____________________ I Prefer to be called: __________
Address:____________________ City:________ State:____ Zip______
Phone (____)________ Work Phone (____)________ Cell Phone (____)________
The best time to contact me is:________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:________ Social Security Number:__________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School__________ City/State__________ ☐ FT ☐ PT
Spouse or Parent's Name:__________ Employer________ Work Phone________
Whom may we thank for referring you? ____________________
Person to contact in case of emergency__________ Phone________
Email Address____________________

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____________________ Relationship to Patient: __________
Address:____________________
City:__________ State:______ Zip:______ Phone: (____)________
Employer__________ Work Phone (____)________ SSN#__________

Section III **Insurance Information**

Name of Insured__________ DOB________ Relationship to Patient ________
SSN#:________ Name of Employer:________ Work Phone: (____)________
Address of Employer:__________ City________ State:____ Zip______
Insurance Company__________ Grp #________ ID#________
Ins Co Address:____________________ Ins Co. Phone:________

--------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ---------

Name of Insured__________ DOB________ Relationship to Patient ________
SSN#:________ Name of Employer:________ Work Phone: (____)________
Address of Employer:__________ City________ State:____ Zip______
Insurance Company__________ Grp #________ ID#________
Ins Co Address:____________________ Ins Co. Phone:________

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______
Are you on a special diet? ◯ Yes ◯ No ______
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Metal Latex
Local Anesthesic Other If yes explain ______

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______

Comments: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE ______

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ACKNOWLEGEMENT

NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ______________________________________, (please print your name) have received a copy of our *Notice of Privacy Practices* regarding the **HIPPA** laws.

____
Patient's Name, if a **MINOR** (please print)

______________________________ ______________(SEAL)
Signature Date

____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, But acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication barrier prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other, please specify ______________________________________
____
____

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PRACTICE POLICY AGREEMENT

If you decline to sign this portion, you must pay for all the services in full when they are rendered. When you are given a dental estimate of patient responsibility, it is due at the time of service. Upon request, we will let you know in advance what your estimate will be, and you will be required to pay that amount at the time of your appointment. THERE WILL BE NO EXCEPTIONS TO THIS RULE. You are responsible for providing our office accurate dental insurance information. We will submit your dental claims to your insurance carrier only once.

I HAVE HEREBY BEEN INFORMED OF THE FOLLOWING:

All broken appointments, either failed, or cancelled with less then a 24 hour verbal notice, will incur a charge of $50.00. This notice includes BUSINESS DAYS only. For example, if you want to cancel a Monday appointment scheduled for 9:00 AM, you have to cancel by 9:00 AM the Friday before. Also, appointments scheduled on a Monday, or the Tuesday after a Monday holiday, need to be cancelled by 5:00 PM the Thursday before. As a courtesy, we will make every attempt to call you and remind you of your appointment day and time.

All Returned (insufficient funds) checks will incur a charge of $35.00 per check.

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing the incorrect medical, contact and / or emergency information can be dangerous to my health. I authorize the dentist to release any information, including diagnosis and records of any treatment or examination rendered to me, or my children during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services rendered. I hereby agree to be responsible for prompt payment of all services rendered on my behalf, or my dependents.

Patient's name (print)____

Signature of responsible party:__________________________________

Relationship to patient:______________________________________

Date of Signature:____

DRS. PORAC & BACHTELL FAMILY DENTISTRY, LLC

RICHARD J. PORAC, D.D.S.
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YEARLY UPDATE

PATIENT INFORMATION

Name: ______________________ Date of Birth ___/___/_____ Social Security # ____-____-____

Address:______________________ City:__________________ State:_______ Zip:__________

Telephone numbers: (H) (   )   -   (W) (   )   -   (Cell) (   )   -

Employer: ______________________ Email:______________________

Physician:__________________ Address:__________________ Tel. # (   )   -

Pharmacy: ______________________ City/Town:__________________

Emergency Contact Person/Relationship:______________________ Tel.# (   )   -

INSURANCE INFORMATION   Do you carry dental insurance?   Yes   No

Insurance Company:__________________ Insured Name: __________________

Insured S.S. # _____-_____-______ Insured Date of Birth: _____/_____/_____ Insured Employer:__________________

Group # __________________ Insurance ID # __________________

MEDICAL INFORMATION

Please List ***ALL*** Medications Currently Taking:

Medication:	Medical Condition:	Dosage:

Please list any serious illnesses or hospital stays:

____

____

Do **you have** or **have had** any of the following problems:

1. Heart disease (murmer, stroke, mitral valve prolapse)	Yes No	7. Hepatitis (A B C Please circle)	Yes No
2. High Blood Pressure	Yes No	8. Arthritis or joints	Yes No
3. Diabetes	Yes No	9. Kidney problem	Yes No
4. Asthma	Yes No	10. Ulcers	Yes No
5. Seizures	Yes No	11. T.B., HIV	Yes No
6. Liver Disease	Yes No	12. Hip, knee, or joint replacement?	Yes No
		13. Allergy to metals or jewelry?	Yes No

PLEASE LET US KNOW IF YOU ARE TAKING ANY VITAMIN E, BABY ASPIRIN, REGULAR ASPIRIN OR ANY BLOOD THINNER ***YES____*** ***NO____***

Circle any **allergic reactions** to the following:

Local Anesthetics – Penicillin – Sulfa – Aspirin – Codeine – Narcotics – Others:______________

Are you experiencing any Dental problems?______________________

Have you had any serious problems associated with any previous dental treatment? ______________________

____

Do you (circle all that apply)   Smoke?   Grind your teeth?   Snore?   Have gums that bleed easily?

Patients Signature: ______________________ **Date** _____/_____/_______