Dr. Harvey Levy & Associates, P.C. 198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702. (301) 663-8300

Welcome to our dental office. In order for us to provide the best dental care for you, it is important to have the following questionnaire completed. All information will be kept strictly confidential. Thank you.

Patient's Name _____ Nickname _____ Date of Birth _____
Last First MI Title

Home Address _____ Zip _____ Phone _____

E-Mail _____ Cell Phone _____ Other Phone/Fax _____

Employment _____ Address _____
(if child, use school)
Phone No. _____ Position _____ How long held _____

Marital Status _____ Soc. Sec. No. _____ Person Financially responsible _____

Husband's or Father's Name _____ Employment _____

Phone No. _____ Position _____ How long held _____

Wife's or Mother's Name _____ Employment _____

Phone No. _____ Position _____ How long held _____

Whom may we thank for referring you to our office? _____

MEDICAL HISTORY: How long since a physician gave you a complete physical exam? _____

Physician's Name _____ Address _____

Are you under care of a physician now? _____ If so, for what reason? _____

Are you taking any medicines, pills or drugs now? _____ If so, what medication and why? _____

Women: Are you pregnant now? _____ If so, what month? _____ Hobbies, Interests _____

Do you have, or have you ever had, any of the following conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Deafness	☐	☐	Nervous Problems
☐	☐	Heart Murmur/Condition	☐	☐	Diabetes	☐	☐	Psychiatric Care
☐	☐	Prolonged Bleeding	☐	☐	Epilepsy / Seizures	☐	☐	Asthma
☐	☐	Herpes I or II	☐	☐	Tuberculosis			ALLERGIES TO:
☐	☐	AIDS / H.I.V	☐	☐	Hepatitis	☐	☐	Aspirin
☐	☐	High Blood Pressure	☐	☐	Radiation Therapy	☐	☐	Penicillin
☐	☐	Low Blood Pressure	☐	☐	Cerebral Palsy	☐	☐	Codeine
☐	☐	Cancer / Malignancy / Tumor	☐	☐	Mental Retardation	☐	☐	Novocain
☐	☐	Artificial Joint / Rod _____	☐	☐	Major Surgery _____	☐	☐	Other _____

Do you smoke? _____ How much? _____

Have you had any hospitalizations in the past 5 years? _____ If yes, what for? _____

Any other medical information the doctor should be aware of? _____

Name, address and phone no. of nearest relative not living at your address _____

REMARKS/UPDATE: _____

_____

DENTAL HISTORY: When was your last dental visit? _____ Dentist's Name _____

Previous dentist's address _____ Phone _____

What was done then? _____ How long since your last cleaning? _____

How often do you brush your teeth? _____ Floss? _____ Any additional oral hygiene aids? _____

Do you have, or have you ever had, any of the following conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	Bleeding gums	☐	☐	Tired jaws	☐	☐	Orthodontic (braces) treatment
☐	☐	Tender/Swollen gums	☐	☐	Clenching teeth	☐	☐	Periodontal (gum) treatment
☐	☐	Loose teeth	☐	☐	Oral habits	☐	☐	Endodontic (root canal) treatment
☐	☐	Sensitive teeth	☐	☐	Burning tongue	☐	☐	Complicated extraction
☐	☐	Mouth sores	☐	☐	Sinus conditions	☐	☐	Crown (cap) or bridge
☐	☐	Pain in mouth	☐	☐	Fear of dentistry	☐	☐	Removable dentures
☐	☐	Ear ache	☐	☐	Sedation for dental work	☐	☐	Implant
			☐	☐	Do you require any medication prior to dental work?	☐	☐	Any unusual dental experience Describe _____

APPOINTMENTS

When time has been reserved for you, an overhead charge of $1.00 per minute will be charged to you for broken or failed appointments.

INSURANCE: All professional services rendered are charged directly to the patient, and patients are personally responsible for payment of fees. We will assist you with the necessary forms to help you obtain your maximum benefits from your insurance company.

Dental Insurance Co. _____

Policy # _____ Group # _____

Employer's full name _____

Employee name _____

Employee birthdate _____

Employee SS# _____

Single/Family Dual coverage _____

I hereby consent to the treatment requested by me, including but not limited to the taking of photographs and dental radiographs for diagnostic purposes, and the use of local anesthetics, relaxants, laughing gas or a combination as required for completing treatment rendered.
I understand that perfect results cannot be guaranteed.
Absent prior written agreement, I understand that a charge of 1.5% per month (18% per annum) will be added to unpaid balances in excess of 60 days past due to defray clerical and accounting costs.
In the event it is necessary to resort to court procedures, I will be liable for the amount due along with all court cost, pre- and post-judgment interest and all other expenses associated with collecting the debt including, but not limited to, all attorney's fees. I certify that all the above information is true and correct to the best of my information, knowledge and belief.

_____ _____
Patient's signature (or parent/guardian) Date