Potomac Crown Dentistry
Precision.Innovation.Compassion.

11908 Darnestown Road Suite A
North Potomac, MD 20878

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Email: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Please list the medications and dosage that you are currently taking: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Potomac Crown Dentistry
Precision.Innovation.Compassion.

11908 Darnestown Road Suite A
North Potomac, MD 20878

Potomac Crown Dentistry Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different.

**** Please note that payment is expected PRIOR to the time of service**** Initials: X_____

If you have dental benefits, we are happy to help you receive your maximum allowable benefits. We will gladly discuss your proposed treatment and answer any questions you have regarding your benefits.

We must emphasize that regardless of what we calculate as your dental benefit, **YOU are responsible for the TOTAL TREATMENT FEE**. As a courtesy, we will submit your insurance claims. We allow 45 days for your insurance company to make payment. AFTER THIS TIME, **THE TOTAL REMAINING FEE NOT COVERED BY YOUR INSURANCE BECOMES YOUR RESPONSIBILITY.** Initials: X_____

An 18% yearly interest fee will be charged on all accounts which are 90 days past due. Additionally, a collection activity fee will be added to accounts which are surrendered to the collection agency.

Potomac Crown Dentistry Broken Appointment Policy

For all broken appointments there is a broken appointment fee ranging from **$50-$150**

- Failing to show to the appointment without 48 hour notice is considered a broken appointment.
- Late cancellations are considered broken appointments. If you need to cancel your appointment, we ask that you please call us at least 48 hours prior to your appointment time.
- Late arrivals are also considered broken appointments. If you arrive 10 minutes into your scheduled appointment time, we reserve the right to reschedule the appointment.

If for any reason an appointment is cancelled or missed without 48 hour notice for a second time within 12 month period, we reserve the right to dismiss the patient from our practice.

Potomac Crown Dentistry Missed Appointment Agreement

- **Appointment Confirmation:** We confirm appointments a week in advance via phone and automated confirmation service. If for any reason the appointment is not confirmed, we reserve the right to replace your appointment with another patient.

  Signature

- **Timely Cancellations:** If you need to cancel or reschedule your appointment, you must give us at least 48 hour notice. Cancellations made with less than 48 hour notice will be considered a missed appointment.

  Signature

  On Time Arrivals: If you are more than 10 minutes late to your appointment, we reserve the right to give the appointment away to another patient. This will be considered a missed appointment

  Signature

Potomac Crown Dentistry
11908 Darnestown Road
Suite A
North Potomac, MD 20878

Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Potomac Crown Dentistry. In providing us with your credit card information, you are giving Potomac Crown Dentistry permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Potomac Crown Dentistry office will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize Potomac Crown Dentistry to charge co-pays and outstanding balances on my account to the following credit card:

Visa	**MasterCard**	**American Express**	**Discover**
☐	☐	☐	☐

Credit Card Holder's Name: _____

Credit Card# _____

Expiration Date: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Patient Signature: _____ Date: _____