DIAMOND DENTAL OF OWINGS MILLS, LLC
Monica Mattson, D.D.S.

WELCOME...as a new patient to our practice, we would like to welcome you. If you are an established patient, we want to thank you for the trust you have placed in Dr. Mattson and our dental team.

YOUR TREATMENT PLANNING...it is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume you are as concerned as we are about maintaining your good health.

DENTAL INSURANCE...the term is misleading. What is commonly known as "dental insurance" is more correctly termed dental benefits. Dental benefits are not intended to pay for everything, but to assist with costs of dental treatment. Generally, dental benefits pay a percentage of some procedures up to a set yearly maximum (most of which have remained the same since the early 1970's). The benefit available to you are established by which plan package your employer has purchased, and may change annually.

IMPORTANT INSURANCE INFORMATION...we recommend that you contact your insurance company for benefit information as all policies differ. Monica Mattson, D.D.S., is not listed as a "preferred provider" or "in network" for any insurance plan; however, as a courtesy to our patients we will submit claims to ALL insurance companies. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion. Please be prepared to put a percentage of your visit down along with your deductible when services are rendered. Once your insurance has paid its allowable amount, you will be responsible for the remaining balance. We do not guarantee any estimate, and we take no responsibility for any denials by the dental plans, as your plan is a contract between you and your insurance company, not us. If your insurance pays the subscriber of the policy directly, we ask that payment be made on the date of service unless financial arrangements have made in advance. **Initials____**

PAYMENT...we feel that everyone benefits when definite financial arrangements are agreed upon. For your convenience we offer several financial arrangement options. We accept personal checks, cash, Visa, MasterCard, Discover, and American Express. We also offer affordable payment plans though Care Credit third party financing. **Initials____**

APPOINTMENTS...for your convenience we offer a wide variety of office hours Monday, Tuesday, Wednesday, Thursday and some Friday and Saturday mornings. Ask about possible early morning and evening weekday hours.

CANCELLATIONS...we try to be respectful of our patient's time when scheduling appointments. Likewise, we ask you respect the time of our other patients and staff members. Please call our office as early as possible if you are in need of a schedule change or delay. Any appointment canceled with less than 24 hours of notice or a missed appointment may be subject to a $50 fee. **Initials____**

PATIENT CONFIDENTIALITY...our office is in compliance with the Federal "HIPPA" Health Insurance Portability and Accountability Act. We will not share your information with anyone other than your insurance carrier, pharmacist, physician, or other dental specialist. I have been given a copy, or have been made available the office's entire HIPPA policy. **Initials____**

I have read and understand the above policies.

_____
Printed Name:

_____ _____
Patient Signature (or Guardian signature) Date:

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

DIAMOND DENTAL OF OWINGS MILLS, LLC

Monica M. Mattson, D.D.S.

HEALTH HISTORY (Confidential)

Name: _____ Today's Date: _____
Birth Date: _____ Date of Last Dental Exam: _____ X-Rays: _____
What is the reason for your visit? _____
Do you consider yourself in good health? _____ Physician: (name/contact info) _____
Are you happy with your smile? _____ _____
Have you ever smoked or used tobacco (circle) products?___ How long? ____ Qty/day? _____
Do you still smoke or use tobacco (circle) products? _____ How long? ____ Qty/day? _____
Have you ever had an oral cancer exam? _____
Are you pregnant? _____ How many weeks? _____
Do you suffer from migraines or muscle tension headaches? _____ How often? _____
Are you aware of clenching or grinding of your teeth? _____ Have you worn/wear (circle) a nightguard? _____
Do you have a history of periodontal (gum) disease?_____
Have you ever had "deep cleanings" or root planing of your teeth? _____ When? _____
Have you ever been pre-medicated before dental appointments? _____ Antibiotics? _____ Anxiety? _____
Do you have a dry mouth? _____
Do you drink sodas or sports drinks? _____ How often?_____
Do you chew gum, chew ice, bite nails, suck on hard candy or cough drops (circle)? _____ How often?_____
Do you get fever blisters or cold sores? _____ How often?_____
Are there any other health issues we should know about? _____
Health History Updates _____ _____ _____ _____ _____ _____ _____ _____ _____

CONDITIONS: Circle Conditions that you HAVE or HAD in the past.

Condition	Please Explain	Condition	Please Explain
Acid Reflux/GERD	_____	Herpes	_____
AIDS	_____	High Blood Pressure	_____
Alcoholism	_____	AIDS / HIV Positive	_____
Anorexia	_____	HPV	_____
Asthma/Inhaler	_____	Joint Replacement/Date	_____
Bleeding Disorder	_____	Kidney Disease	_____
Blood Transfusion	_____	Liver Disease	_____
Bulimia	_____	Migraine Headaches	_____
Chemical Dependence	_____	Pacemaker/Defibrillator Implant	_____
Cancer/Type/Treatment	_____	Psychiatric Care/Medication	_____
Diabetes/Type/Controlled?	_____	Subacute Bacterial Endocarditis	_____
Emphysema	_____	Stroke / T.I.A.	_____
Epilepsy	_____	Thyroid Problems	_____
Heart Disease	_____	Tuberculosis	_____
Heart Murmur	_____	Ulcers	_____
Hepatitis/Type	_____	Other	_____

Patient is responsible for notifying the dentist of any changes in their health or medications. Initials___

MEDICATIONS: (List of medication and dosages currently taking) _____
_____
VITAMINS, SUPPLIMENTS, RECREATIONAL DRUGS: (What and how often)_____
_____
ALLERGIES: (To medications or substances)_____
_____
Do you have any scheduling preferences? _____
Morning, Afternoon, Evening, Weekends (circle)? M, Tu, W, Th, F, Sa? ONLY?
Communications preferences (circle)? Email, Text, Home Phone, Cell Phone, Written, Language
Personnel Requests? _____
Do you require any special needs while receiving care here? _____
Ex. wheelchair access, no stairs, blanket, no music, headphones

DIAMOND DENTAL OF OWINGS MILLS, LLC
FINANCIAL POLICY

Overview **Patient Name**_____

Thank you for choosing our office for your dental needs. We continually strive to provide our patients with the finest care. Dental treatment is an excellent investment in an individual's medical and psychological well-being. We work hard to discuss your dental care, the risks and benefits to various treatments, and associated fees before beginning any treatment. We realize that every patient has different financial situations; therefore, we are prepared to offer our patients a variety of payment options to allow you to receive the dental care that you deserve. To maintain efficient practice operations, and prevent any misunderstanding, we ask that you review our financial policies.

Payment for dental services provided are due at the time of service unless other arrangements have been made in advance. For patients with dental insurance, your deductible and copay are due on the date of service. We will work with you to maximize your insurance benefits, but keep in mind, you are fully responsible for all fees associated with treatment, regardless of insurance coverage.

For your convenience, we accept cash, checks, Visa, MasterCard and Care Credit (third party financing).

When a balance is due on your account, you will receive a monthly statement. After 90 days, any unpaid may be eligible for a collections agency.

Please contact our office if your statement does not reflect your insurance company's payment within the four to six weeks following your treatment. Any remaining balance after your insurance company has paid is your responsibility, and prompt payment is appreciated. Note: Adults 18-26 years old using their parent(s) insurance, financial arrangements are your responsibility, but you may want to include your parent(s) in financial discussions.

Discounts and Financing Plans

-Pay As You Go: Simply complete treatment at a pace that is comfortable with your personal finances.

-5% Pre-pay Cash or Check Discount: On treatment greater than $1500 when paid by check or cash on or before the date of service.

-3% Pre-pay Credit Card Discount: On treatment greater than $1500 when paid by credit card on or before the date of service.

-Special Service Payment Option: On occasion, the doctor may opt to allow for an extended in office payment plan. This treatment option would allow the patron to spread the payment of treatment over 3 months by paying half of the treatment cost on the date of service, then pay the remaining balance in 2 equal subsequent monthly payment. Month 1 = 50% total balance fee, Month 2 = 25% total balance fee, Month 3 = 25% total balance fee (Paid in Full). This option MUST be agreed upon BEFORE service is rendered.

-Care Credit Healthcare Financing: Healthcare financing allows you the flexibility of applying for several convenient financing plans. Upon completion a short credit application and approval by Care Credit, you may select 3, 6, or 12 months *interest free* financing, or 18-60 month plans from 4.99% to 14.90% depending on your credit score. More information may be found at www.carecredit.com

I have been presented these options: _____ Date:_____
Signature or Guardian's Signature