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 any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health. Thank you in advance for the trust you have placed in Dr. Mattson and our dental team.

YOUR TREATMENT PLANNING...our goal is to provide all of our patients the best personalized dentistry. To do this, it is important that we do not allow insurance benefits to be a determining factor in our diagnosis. Your treatment plan will be based upon your personal need, together we will focus on achieving and maintaining your oral 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 fully cover all services, rather to assist with the costs of dental treatment. Generally, dental benefits cover a set percentage of preventative and restorative procedures. However, the coverage is limited to a yearly maximum dollar amount and subject to annual deductibles and copays. The benefits available to you are established by your employer and the insurance company they have contracted with, the terms of may change annually.

IMPORTANT INSURANCE INFORMATION...we recommend that you personally review your specific dental insurance benefits, as all policies differ. Diamond Dental of Owings Mills and Monica Mattson, D.D.S. are not contracted providers for any insurance plan; however, as a courtesy to our patients, we do submit claims to most insurance companies. Please be prepared to pay a percentage of your visit along with your deductible on the date services are rendered. Once your insurance has paid its allowable amount, you are responsible for any remaining balance. Our office does not guarantee any estimates and we take no responsibility for any denials by the insurance company. Some insurance companies reimburse the policy holder directly, in such cases we ask that full payment be made on the date of service unless financial arrangements have made in advance. **Initials____**

PAYMENT...we feel that everyone benefits when financial arrangements are agreed upon in advance. For your convenience, we accept several forms of payment including cash, Visa, MasterCard, Discover and American Express. We also offer affordable payment plans through Care Credit, a third-party financing company. **Initials____**

APPOINTMENTS...for your convenience we offer extended office hours available on Monday, Tuesday, Thursday and alternating Friday and Saturday mornings.

CANCELLATIONS...we try to be respectful of our patient's time when scheduling appointments. Likewise, we ask you to consider our staff who prepare and reserve their time to focus specifically on your needs. Please call our office as early as possible if you need to reschedule. Any appointment canceled with less than 24 hours of notice or a missed appointment will be subject to a $50 fee. **Initials____**

PATIENT CONFIDENTIALITY...our office is in compliance with the Federal Health Insurance Portability and Accountability Act, “HIPAA.” We will not share your information with anyone other than your insurance carrier, pharmacist, physician or other dental specialist. A copy of DDOM’s HIPAA policy has been made available for my review. **Initials____**

I have read and understand the above policies.

____
Printed Name

____ ____________________
Patient Signature (or Guardian signature) *Date*

FINANCIAL POLICY

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 the following financial policies.

Payment for dental services are due at the time of service unless written financial arrangements have been made in advance. For your convenience, we accept cash, Visa, MasterCard, Discover and Care Credit (third party financing). We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

For patients with dental insurance, your deductible and estimated copay percentage 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. **While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.** Any remaining balance after your insurance company has paid is your responsibility, you will receive a monthly statement. Please note, adults 18-26 years old using their parent(s) insurance, financial arrangements are your responsibility, however, we recommend that you include your parent(s) in treatment planning and financial decisions.

Any outstanding balances older than 30 days will be subject to interest charges of **1.5% per month**. Returned checks will be subject to a **$35.00** bad check fee. Additional, charges may also be made for broken or canceled appointments without 24 hours advance notice. After 90 days, unpaid accounts will require a third-party to collect an outstanding account balance, the patient shall be responsible for the reasonable cost (35% of the past due balance) of a collection agency, attorney, and/or court costs.

Should you have any questions regarding your account please contact our office staff as soon as possible.

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 Discount: On treatment greater than $1500 when paid in full with cash on or before the date of service.
- 3% Pre-pay Credit Card Discount: On treatment greater than $1500 when paid in full by credit card on or before the date of service.
- Dental Savings Plan: Diamond Dental offers an in-office membership plan. Patients pay an annual discounted fee that entitles them to two examinations per year, two teeth cleanings (in the absences of infection), oral cancer screening, necessary x-rays and optional Fluoride treatment for FREE. Additionally, members are then entitled to 10-15% off other services offered at Diamond Dental. Ask us for details today!
- 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, qualified candidates may select 3, 6, or 12 months *interest free* financing. Extended 18-60 month plans are subject to interest rates through the lender and may not be offered by Diamond Dental. More information may be found at www.carecredit.com

The undersigned hereby waives any defense he/she may have as to the Statute of Limitations barring future attempts to recover debts owed hereunder in the event of default.

I understand the financial options:

____
Printed Name

____ ________________
Patient Signature (or Guardian signature) Date

Diamond Dental OF OWINGS MILLS

PATIENT INFORMATION

Name ______________________________ Soc. Sec. # ______________
Last Name *First Name* *M.I.*

Address ______________________________

City ______________ State ________ Zip __________ Home Phone ______________

Cell Phone ______________ Email: ______________

Sex: _______ Age ________ Birthday __________ Martial Status ______________ How did you hear about our office? ____________

EMERGENCY CONTACT

Name #1 ______________________ Relationship ______________________

Phone ______________________

PRIMARY INSURANCE – please provide a copy of your insurance card(s) to our front desk staff

Name of Insured ______________________________ Phone Number ______________
Last Name *First Name* *M.I.*

Relationship to patient ______________ Birth date ______________ Soc. Sec. # ______________

Employer ______________________________

Insurance Company ______________________________

Group Number ______________________ Subscriber ID Number ______________________

ADDITIONAL INSURANCE (Please provide information about additional insurance policies to our front desk staff)

HIPAA CONSENT FOR THE RELEASE OF INFORMATION

I hereby give my consent for Diamond Dental of Owings Mills to disclose protected health information ("PHI" including appointment reminders, treatment options and financial information) about me or my dependents to the following trusted persons in conformance with Diamond Dental of Owings Mills Notice of Privacy Practices ("NPP"). Diamond Dental of Owings Mills NPP more completely describes circumstances in which such information may be disclosed.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Diamond Dental of Owings Mills and its affiliates reserve the right to revise the Notice of Privacy Practices at any time.

I grant permission to the staff Diamond Dental of Owings Mills to share information with the following people:
(List spouse, parent, guardian, significant other, children etc.)

Name #1 ______________________ Name #2 ______________________

Relationship ______________________ Relationship ______________________

Phone ______________________ Phone ______________________

____
Printed Name

______________________________ ______________
Patient Signature (or Guardian signature) *Date*

Diamond Dental
OF OWINGS MILLS

HEALTH HISTORY

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Alcoholism	☐ Anemia	☐ Anorexia	☐ Arthritis
☐ Artificial Joints	☐ Asthma/ Inhaler	☐ Bleeding Disorder	☐ Blood Disease
☐ Blood Transfusion	☐ Bulimia	☐ Cancer	☐ Chemical Dependency
☐ Diabetes - Type 1	☐ Diabetes - Type 2	☐ Dizziness	☐ Emphysema
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ Herpes / Cold Sores	☐ High Blood Pressure	☐ HIV/AIDS	☐ HPV
☐ Jaundice	☐ Joint Replacement	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Migraines/Headaches	☐ Nervous Disorders	☐ Other- Explain below
☐ Pacemaker	☐ Psychiatric Care/Med	☐ Radiation/ Chemo Tx.	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems	☐ STD / HPV
☐ Stomach Problems	☐ Stroke/ T.I.A.	☐ Sub Bac Endocarditis	☐ Thyroid Problems
☐ Trigeminal Neuralgia	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Vertigo			

☐ Subject to frequent headaches ☐ Tobacco/Alcohol Use ☐ FEMALE: Current Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

____
____
____

MEDICATIONS: Please list all prescription and non- Prescription, including regular doses of aspirin, herbal supplements, vitamins, birth control pills and recreational drugs.

____
____
____

ALLERGIES: Include allergies to medications

____
____
____

PREFERRED PHARMACY

Name ______________________

Address ______________________

Phone ______________________

PRIMARY CARE PHYSICIAN

Name ______________________

Address ______________________

Phone ______________________

What is the primary reason for your visit? ______________________

Date of Last Dental Exam: ______________________ X-Rays: ______________________

Are you happy with your smile? *If not please explain what you would like to change* ______________________

____