We are pleased you have selected us to provide dental care for you and your family.

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

Patient Information

Date _____ Patient's Name _____ (Last) (First) (Middle)

Address _____ (Street) (Unit#) (City) (State) (Zip)

Home Ph. # (_____) _____ Work Ph. # (_____) _____ Cell Ph. # (_____) _____ Marital Status _____

Soc. Sec. # _____ - _____ - _____ Drivers Lic. # _____ E-Mail: _____

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

If patient is a full-time student, fill in school name _____

School Address _____ Ph. # (___) _____

Emergency Contact _____ Ph. # (___) _____

Responsible Party Information

Name _____ (Last) (First) (Middle)

Soc. Sec. # _____ - _____ - _____ Birthdate _____/_____/_____ Relationship to Patient _____

Residence _____ (Street) (Apt#) (City) (State) (Zip)

Mailing Address _____ (Street) (City) (State) (Zip)

How long at this address _____ Home Ph.# (___) _____ Work Ph.# (___) _____ Fax# (___) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____

Soc. Sec. # _____ - _____ - _____ Birthdate _____/_____/_____ Work Ph.# (___) _____ Fax# (___) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

Dental Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the last two years? YES NO
3. Are you now taking any medication or drugs? YES NO

   If yes, please list: _____

4. A. Have you taken any medication or drugs during the last two years? YES NO

   B. Have you ever taken bisphosphonate medications for Osteoperosis or other bone loss related issues? YES NO
5. Have you been under the care of a medical doctor during the last two years? YES NO

   Physician's Name _____ Ph. # (___) _____

   Address _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Osteoporosis	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes, which strain? (circle)	A	B C
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO
						If yes, date _____		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than ten pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO

    If yes, please list: _____
15. Do you smoke? YES NO

FOR WOMEN ONLY:
Are you pregnant? Yes___ What month? _____ No___ Are you nursing? Yes___ No___ Are you taking birth control pills? Yes___ No___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Print Name _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for the patient's treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient _____ Date _____ Witness _____

Print Name _____

Guardian/Responsible Party if minor _____ Relationship to Patient _____

Print Name _____ Date _____

OFFICE USE: Reviewed by Dr. _____ Date _____

TAIRA DENTISTRY

Gregg S. Taira, D.D.S.
Janine A. Taira, D.D.S.

2 Professional Dr, Ste 245
Gaithersburg, MD, 20879
(301) 963-9690
doctaira@tairadentistry.com

Office Financial/Insurance/Privacy Policy

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for our services at the end of each visit. Our front desk staff can provide you with the approximate fee for treatment before your appointment upon request. Please do not hesitate to ask for an estimate. To make payments convenient for you, we accept ***cash, personal and business checks, Visa, MasterCard, and Discover.***

Dental Insurance

We are ***out-of-network*** for ALL managed care/network insurance plans. Insured patients should read their policies carefully to become familiar with its benefits and limitations. It is important that you understand that insurance is usually designed to reduce your cost, not eliminate it completely. Benefits and limitations vary widely between different insurance carriers and employers. As a new patient, you are responsible for the total cost of your first visit regardless of your insurance coverage. Insurance will be submitted as a courtesy to you, and we will reimburse you for any insurance payments due to you. Secondary insurance submission is your responsibility. We will assist you by providing copies of history and/or past claims. Please remember your insurance disclaimer states that benefit information is not a guarantee of payment. Thus, you are responsible for the full charges regardless of the actual insurance payment, maximum benefit allowances reached, and time limitations.

Your Financial Responsibility

If your account is outstanding for more than 45 days, a monthly service charge of 1.5% (18% APR) will be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service and you will be responsible for a $30 collection fee, plus attorney's fees and court costs. A billing fee of 5% per statement may also be charged after the initial billing period.

Failed appointments will be subject to a missed appointment fee unless canceled at least 24 hours in advance. This will be charged at a rate of $50.00 for each hour of time block scheduled.

Returned checks are subject to an additional fee of $35.00. Immediate remittance in the form of cash, money order, or certified funds is required.

I have read the above policy and agree to accept financial responsibility.

I authorize the release of any information necessary to process my claim.

I will assign insurance benefits directly to Dr. Gregg Taira, if allowed.

I have read the office **HIPAA policy** and may request a copy.

Name: _____

Signature acceptance: _____Date: _____

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Gaithersburg, MD, 20879
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doctaira@tairadentistry.com

Agreement to Receive Electronic Communication

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails and text messages.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 301-963-9690 or emailing the office at doctaira@tairadentistry.com.

Patient Name: _____ Date of Birth: _____

Email Address (PLEASE PRINT CLEARLY):

_____

Cell Phone for texting (Carrier charges may apply):

_____

Patient Signature: _____ Date: _____