Smart Dental
9501 Old Annapolis Rd. Ste. 200 A
Ellicott City, Maryland 21042
Dr. HeeJung Kim

□ Mr.□ Mrs.□ Ms.□ Miss. □ Dr. **Patient Name**: ____

Address: ____________________________________City, State, Zip:______________________________

Home Phone:__________/__________/__________ Work Phone__________/__________/_________

Cell:__________/__________/__________ E-Mail:____

Birth Date:________/________/________ Social Security No.:__________/__________/__________ _

Employer Name and Address:____

____

Physician Name and Phone No.: ____

Date of Last Medical Exam:______/______/______ Date of Last Dental Exam______/______/_______

Pharmacy Name and Phone No.:____

●●

□ Mr.□ Mrs.□ Ms.□ Miss. □ Dr. **Guarantor Name**:____

Address:____ City, State, Zip:______________________

Home Phone:__________/__________/_________ Work Phone:__________/__________/__________

Cell:__________/__________/__________ E-Mail:____

Birth Date:_________/_________/_________ Social Security No.:__________/__________/_________

Employer Name and Address:____

____

Dental Plan Name:____ Group No.:_________________

Claims Address:_____________________________ City, State, Zip:________________________________

Dental Insurance No.:__________/__________/__________ Member ID _________________________

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Please answer if you have or have had the following:

Y N Conditions	Y N Conditions	Y N Conditions
☐☐ Abnormal Bleeding	☐☐ HIV / AIDS	☐☐ Ulcers
☐☐ Alcohol Abuse	☐☐ Heart Attack	☐☐ Diabetes
☐☐ Tuberculosis	☐☐ Allergies	☐☐ Heart Surgery
☐☐ Hepatitis ☐A ☐B ☐C	☐☐ Stroke	☐☐ Hemophilia
☐☐ High Blood Pressure	☐☐ Artificial Bones	☐☐ Latex Allergy
☐☐ Low Blood Pressure	☐☐ Arthritis	☐☐ Yellow Jaundice
☐☐ Anemia	☐☐ Artificial Heart Valve	☐☐ Liver Disease
☐☐ Asthma	☐☐ Mitral Valve Prolapse	☐☐ Cancer-Chemotherapy
☐☐ Kidney Problems	☐☐ Frequent Headaches	☐☐ Thyroid Problems
☐☐ Congenital Heart Defect	☐☐ Difficulty Breathing	☐☐ Shingles
☐☐ Fainting Spells	☐☐ Sinus Problems	☐☐ Angina Pectoris
☐☐ Seizures	☐☐ Fever Blisters	☐☐ Venereal Disease
☐☐ Glaucoma	☐☐ Pace Maker	☐☐ Birth Control Pills
☐☐ Smoke or use Tobacco	☐☐ Blood Transfusion	☐☐ Are you Pregnant
☐☐ Bleed Easily	☐☐ Sickle Cell Disease	If yes # of week's _____
☐☐ Epilepsy	☐☐ Drug Abuse	☐☐ Are you nursing

Height: _____ Weight: _____

Y N Allergies

☐☐ Aspirin ☐☐ Codeine ☐☐ Dental Anesthetics ☐☐ Erythromycin ☐☐ Latex

☐☐ Metals ☐☐ Penicillin ☐☐ Tetracycline **Other:**_____

Are you happy with the color of your teeth? _____

Are you happy with your smile? _____If not are you interested in Braces/Invisalign?_____

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Please list all current medications:

Name:_____ Reason:_____

Name:_____ Reason:_____

Name:_____ Reason:_____

Name:_____ Reason:_____

Name:_____ Reason:_____

Is there is disease, condition, or problem that you think the office should know about that is not covered above? □Y □N If yes please describe below…

_____

_____

_____

It is the policy of this office to charge a broken or missed appointment fee of $ 50.00 per half-hour for appointments not canceled with a 24 hour notice. Under 3-512 of The Commercial Law Article you may be liable for three times the amount of the check in District Court if your check remains unpaid after 30 days notice. In addition, you may be prosecuted under Maryland Criminal Code, Article 27, and Section 140-144. A $40.00 collection fee may be accessed on any check returned. There is a re-billing charge of $1.50 for each statement sent after 30 days. As a courtesy, we will provide an estimate of your co-pay. Your exact co-payment will be determined by **Your Insurance Carrier** as your claim is processed. If your account is sent to collections you will be responsible for your account balance and all fees associated with the collection process. This can be up to 33 ½ % of the total balance. If you have read and agree to the terms above please sign and date below.

Print Name:_____

_____ _____/_____/_____

Signature of Patient/Parent/Guardian if minor "SEAL" Date