PATIENT INFORMATION

Patient's Name: Last			First	Middle	Referred By:	Referring Dr.'s #:
Date of Birth:	Age	Sex	Soc. Sec. #	Day Time Phone #		Family Doctor:
Street Address/Mailing Address/City/State/Zip				Emergency Contact: Relationship: Phone #:		Dentist: Orthodontist:
Employer:			Address:	Employer Phone #		
Spouse's Name:			Employer:	Employer Phone #		

Email: ____

For minors, students or individuals under their parents insurance:

Father's Name:	Address:	Phone:	Date of Birth:	Soc. Sec. #
Employer:		Employer Phone #		
Mother's Name:	Address:	Phone:	Date of Birth:	Soc. Sec. #
Employer:		Employer Phone #		

Current medications & Dosage	Please list allergies	Hospitalizations/Surgeries

Answer by circling Y (yes) or N (no) subject to our Protected Health Information Policy and Consent.

- Are you in good health? Y N
- Has there been any change in you general health in the past year? Y N
- Are you under a physician's care for a particular problem? Y N If yes, explain:________________________
- Have you ever had any adverse effects from dental treatment? Y N If yes, explain:________________________

Habits: Alcohol? yes/no how much?_______ Tobacco? yes/no how much?______ Drugs? yes/no how much?_____

Female patients must read, complete and sign the following:

- Are you now or do you think you may be pregnant? Y N
- If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics or any medication may significantly harm your developing baby, especially during the first trimester.
- Do you take birth control pills? Y N

Antibiotics may be prescribed for me while I am treating by Dr. Ascher. Medications may interfere with the effectiveness of oral contraceptive pills. I understand an alternative birth control is needed if antibiotics are prescribed.

Signature: _______________________________________

I understand the importance of a true and reliable health history to assist the doctor in providing the best care possible.
I certify that the information on this form is true and correct:

Patient's signature: **X**____ **Date:**___________________

(Parent or legal guardian must sign if patient is a minor or incapacitated)

Relationship if not patient: ____________________________

Patient information (continued)

Do you or any family member have a history of: **Height**________ **Weight (lbs.)** ________

Cancer *Heart Disease* *Diabetes* *Thyroid Disease* *Kidney Disease* *Lung Disease*

- **Have you had any disease, drug or transplant operation that has depressed your immune system?** YES NO

Please circle Y (yes) of N (no) for all of the following: All responses are kept confidential. Provide details for any "yes" answers in this space including nature of condition and related history:

____

____

Condition	Y	N	Condition	Y	N
Environmental Allergies	Y	N	Heart Murmur	Y	N
Headaches (frequent)	Y	N	Rheumatic Fever	Y	N
Head Injury	Y	N	Heart Disease	Y	N
Epilepsy	Y	N	Abnormal Blood Pressure	Y	N
Glaucoma/Eye Problems	Y	N	Anemia	Y	N
Sinus Problems	Y	N	Bleeding Problems	Y	N
Nose Problems/Nasal Obstruction	Y	N	Blood Disorder	Y	N
Frequent Nose Bleeds	Y	N	Blood Vessel Disorder	Y	N
Frequent Sore Throats	Y	N	Kidney Disease	Y	N
Throat Problems	Y	N	Venereal Disease	Y	N
Pneumonia/Tuberculosis	Y	N	Tumors/Cancer/Radiation	Y	N
Implants-heart, hip, knee, other	Y	N	Diabetes	Y	N
Stomach Ulcers/Disorder	Y	N	Stroke	Y	N
Intestinal Disorder	Y	N	Thyroid Problems	Y	N
Jaundice/Hepatitis	Y	N	Gland Problems	Y	N
Liver Disease	Y	N	Steroid Problems	Y	N
Recurrent Infections	Y	N	Seizures/Convulsions	Y	N
Skin Rash or Disease	Y	N	Arthritis	Y	N
Asthma/Emphysema	Y	N	Fainting	Y	N
Lung Disease/Chronic Cough	Y	N	Emotional Problems	Y	N
Heart Attack/ Chest Pain	Y	N	Nerve Problems	Y	N
Shortness of Breath	Y	N	Jaw pain/ clicking	Y	N
Broken Bones/Bone Problems	Y	N	Transplants- organs, tissue	Y	N

- **Do you have any disease or problem not listed above that the doctor should know about?** YES NO
  If yes, specify: ____

I understand the importance of a true and reliable health history to assist the doctor in providing the best care possible.
I certify that the information on this form is true and correct:

Patient's signature: X____ **Date**:_____________________

(Parent or legal guardian must sign if patient is a minor or incapacitated)

Relationship if not patient*:* ______________________________

This section is only to be signed if you are a previous patient needing to update information.

I have read and reviewed my health history _____/_____/______ and have made any necessary changes.

_________________ ____

Date Signature (patient, parent or legal guardian)

OFFICE FINANCIAL POLICY & AGREEMENT (ALL PATIENTS):

Dr. Lynn F. Ascher, P.A., (Provider) offers services conditioned on payment from you on terms acceptable to Provider. Patients over the age of eighteen (18), and/or any other party assuming responsibility for payment of the services or consenting to the services for any other person (also, "Patient") are subject to this Agreement. Persons or agents acting for an incapacitated person, minor, or otherwise assuming payment responsibility may be asked to provide written proof of legal authority or relationship. Provider routinely requires proof of identity including photographic identification as a condition of providing services.

Payment is required in advance of service based on our Patient "ESTIMATE" which represents an approximate fee for office services that will likely be provided to you: pre-procedure estimates are merely estimates and the final amount due may vary due to complications, undetermined scope of work, emergent conditions, or unanticipated procedural and support needs as required by the Patient.

Provider's services are subject to pre-procedure confirmation of payment and verification of receipt of funds usually based on the estimate provided in advance. Failure to arrange for payment in advance in a timely manner may result in the re-scheduling of your procedure and the assessment of costs as detailed herein. Upon completion of services, payment is required for any balance due above the estimated amount.

"LATE CANCELLATIONS, NO SHOW FEES AND COSTS": Patients that fail to pay in advance or do not present themselves for scheduled appointments will be charged the sum of $100.00 as a "no-show" plus the costs any related medical, dental, anesthesia, or other procedural support supplies and materials reserved for a procedure unless 24 hours advance notice has been provided to this office.

Provider accepts VISA, MASTERCARD, CASH, PERSONAL and BANK CHECKS; if necessary, a convenience or user fee of 3.5% may be added to card payment processing to cover related bank or processor fees. Unpaid accounts incur finance charges of 2% per month from date of service plus collection costs of 40% of the unpaid balance for administrative and related expenses related to the unpaid services and balance; these costs become part of your account balance due to us.

Returned checks are subject to a return fee of the higher of $35.00 or maximum allowed by law, legal enforcement or other collection action. Unpaid balances accrue applicable finance charges, and may incur collection fees, bad check fees, legal costs and attorney's fees allowed by law. Patient agrees the District Court of Maryland for Wicomico County, Maryland or the Circuit Court of Wicomico County, Maryland, shall be the exclusive venue for all legal actions except as otherwise elected by Provider in its sole discretion.

ANY ESTIMATE I have received is subject to Provider's applicable Office Financial Policy and Agreement and representative only of fees charged for routine similar procedures. An Estimate relates only to the services described and does not include costs arising from complications or undetermined treatment needs such as medical, surgical, procedural, anesthesia, or other treatment and support. Out of Office procedures are subject to facility, hospital, surgery center, support fees which may not be included in this Estimate. Any Estimate I have received relates only to Provider's professional fees for the service described and does not include charges or expenses arising under the Office Financial Policy or Agreement such as finance charges or "no show" fees, administrative fees, reasonable attorney fees, collection costs, etc.

In all instances, I agree that I am responsible for payment for all services received from Provider according to the terms set forth above notwithstanding that other payment sources may also be responsible to me for payment or contribution to payment of these services.

Patient Initials: ___________ Responsible Party Initials: ____________

OFFICE FINANCIAL POLICY & AGREEMENT (ALL PATIENTS)

PRE-PROCEDURE PAYMENTS: I UNDERSTAND THAT IF PRE-PROCEDURE PAYMENT REQUIREMENTS ARE NOT MET TO THE SATISFACTION OF PROVIDER THAT PROCEDURES MAY BE SUBJECT TO CANCELLATION AND RESCHEDULING BY PROVIDER IN ITS DISCRETION AND ASSESSMENT OF RELATED COSTS INCURRED AS AN AMOUNT DUE HEREUNDER.

I AGREE TO ALL STATED PROVISIONS, POLICIES, AND TERMS. I AGREE TO PAY FOR AND ACCEPT FINANCIAL RESPONSIBILITY FOR ALL AMOUNTS DUE FOR PROVIDER'S SERVICES TO ME OR THE PATIENT NAMED BELOW AND ALL RELATED COSTS INCURRED BY PROVIDER ON MY BEHALF. IF PREPROCEDURE PAYMENT REQUIREMENTS ARE NOT MET TO THE SATISFACTION OF PROVIDER, I AGREE THAT SERVICES MAY BE CANCELLED AND RESCHEDULED BY PROVIDER IN ITS DISCRETION.

____________________________	**X**____
Witness	**Patient's signature (parent or legal guardian signs below)**
	Printed Full Name: ______________________________
	Date: ________________
____________________________	**X**____
Witness	**Signature of parent (s) or legal guardian**
	Printed Full Name: ______________________________
	Date: ________________
____________________________	**X**____
Witness	**Other Responsible Party or Guarantor's Signature**
	Printed Full Name: ______________________________
	Relationship to patient: ___________________________
	Date: ________________

Dr. Lynn F. Ascher, P.A., 560 Riverside Dr., Suite B201, Salisbury, MD 21801 Tel: 410-543-1675 Fax: 410-543-1763

OFFICE INSURANCE PROCESSING POLICY & AGREEMENT with ASSIGNMENT OF BENEFITS (if applicable):

Insurance is designed to reduce your cost **NOT** to eliminate it. If you assign your insurance benefits to us, we reserve the right to bill your insurance as a courtesy to you provided you give us accurate and timely proof of insurance in advance of any covered procedure. As Provider, we cannot compel your insurance to pay or to cover our services; as the Patient you have primary responsibility for payment of our services; as the Insured, you are ultimately responsible for confirming coverage and obtaining payment from your insurance company. Whether or not your insurance pays or covers the services, you agree to pay Provider as agreed. It is your responsibility to confirm that your insurance is in effect, current at the time of service, covers the procedure, has been pre-authorized as required by your insurer, and correctly documented to us. **Note:** Insurance is typically subject to periodic or annual limitations, deductibles, co-pays, or co-insurances, caps, gaps, or contribution limits or pre-approval requirements including advance written notice.

Confirm your Dental, Medical, Medicare, Medicaid, or other insurance is current, paid, effective, and applicable to the procedure, and correctly provide the following information with any proof of insurance requested:

Name of Dental Insurance Company: ____ Phone: ________________
Address for Claims: ____
Policy or ID#: ______________________ Group#____________________ Effective Date: _______________
Subscriber's Name: _______________________Social Security #: ________________Date of Birth: ____________

Name of Medical Insurance Company: ____ Phone: ________________
Address for Claims: ____
Policy or ID#: ______________________ Group#____________________ Effective Date: _______________
Subscriber's Name: _______________________Social Security #: ________________Date of Birth: ____________

Other Source Name: ____ Phone: ________________
Address for Claims: ____
Policy or ID#: ______________________ Group#____________________ Effective Date: _______________
Subscriber's Name: _______________________Social Security #: ________________Date of Birth: ____________

You authorize this Office to submit insurance forms and release information to your insurer after the procedure is done; agree to pay any deductibles, co-pays, co-insurances, account balances, or other amounts determined to be due by the Provider at the time of service; fully pay any portion of the bill for services as agreed; understand and agree to be responsible for coordinating payment of insurance benefits from your Insurer, cooperate with this office and the insurance company to obtain payment; agree to meet all pre-procedures requirements of the insurance company, obtain pre-approvals, prior to the time of service, if required by your insurer. I understand that my insurance plan may have annual or periodic limitations as to amount, type of service, scope of coverage, etc., that may limit coverage amounts from the insurer.

PATIENT CONSENT TO PROVIDER RELATED TO RELEASE OF INFORMATION: I AUTHORIZE RELEASE OF ANY INFORMATION BY THIS OFFICE RELATED TO MY CLAIM FOR ALL REQUIRED PURPOSES. If applicable, I authorize, direct, and assign payment of insurance, personal injury and other benefits otherwise payable to me directly or any agent I employ, to Dr. Lynn F. Ascher, P.A., and agree to pay any balance not so paid subject to the aforesaid Office Financial Policy and Agreement. I agree that a photocopy of the Agreement shall be valid as the original.

IMPORTANT NOTICE: I AGREE THAT ANY INSURANCE IS NOT A SUBSTITUTE FOR MY OBLIGATION TO PAY PROVIDER FOR THE SERVICES RECEIVED. In all instances, I agree that I am responsible for payment for all services received from Provider according to the terms set forth above notwithstanding that other payment sources may also be responsible to me for payment or contribution to payment of these services.

Patient Initials: ____________Responsible Party Initials: ____________

THERE FOREGOING DOES NOT AFFECT REQUIRED PRE-PROCEDURE PAYMENTS: I UNDERSTAND THAT IF PRE-PROCEDURE PAYMENT REQUIREMENTS ARE NOT MET TO THE SATISFACTION OF PROVIDER THAT PROCEDURES MAY BE SUBJECT TO CANCELLATION AND RESCHEDULING BY PROVIDER IN ITS DISCRETION AND ASSESSMENT OF RELATED COSTS INCURRED AS AN AMOUNT DUE HEREUNDER.

I AGREE TO ALL STATED PROVISIONS, POLICIES, AND TERMS. I AGREE TO PAY FOR AND ACCEPT FINANCIAL RESPONSIBILITY FOR ALL AMOUNTS DUE FOR PROVIDER'S SERVICES TO ME OR THE PATIENT NAMED BELOW AND ALL RELATED COSTS INCURRED BY PROVIDER ON MY BEHALF. IF PRE-PROCEDURE PAYMENT REQUIREMENTS ARE NOT MET TO THE SATISFACTION OF PROVIDER, I AGREE THAT SERVICES MAY BE CANCELLED AND RESCHEDULED BY PROVIDER IN ITS DISCRETION.

____________________________	X____
Witness	**Patient's signature** (parent or legal guardian signs below)
	Printed Full Name: ______________________________
	Date: ________________
____________________________	X____
Witness	**Signature of parent (s) or legal guardian**
	Printed Full Name: ______________________________
	Date: ________________
____________________________	X____
Witness	**Other Responsible Party or Guarantor's Signature**
	Printed Full Name: ______________________________
	Relationship to patient: ___________________________
	Date: ________________