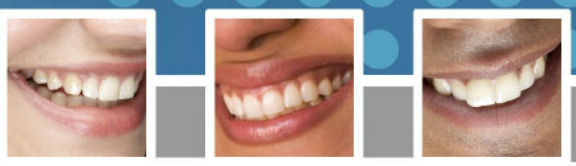
Ballenger Creek Dental Associates
Mark C. LeMonnier, D.D.S.
6550 Mercantile Dr E, Ste #204
Frederick MD 21703
(301)663-0811
drmark@ballengercreekdental.com
www.ballengercreekdental.com



Patient Information

Welcome to our practice! We're glad you've given us the opportunity to show you how to keep your smile healthy. Please take a moment to tell us a little about yourself.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

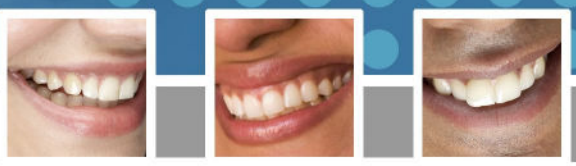
Employer Name: _____ Phone: _____

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

Name of person, office, or other source referring you to our practice:

_____

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Primary Dental Insurance Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ _____ _____ _____
Last First MI Preferred Name

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

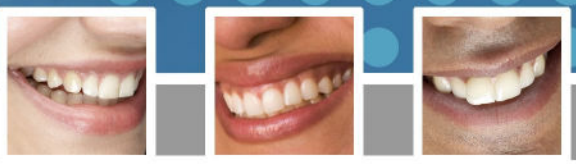
Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

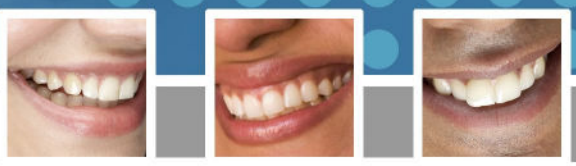
I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Relationship to Patient:

Response Date:

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Medical & Dental History Form

In order that we may better serve you in a manner consistent with your overall health and well-being, please take a moment to tell us about your medical and dental experiences.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Do you take antibiotic pre-medication prior to your dental treatment?

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

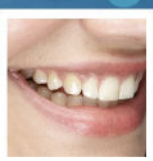
☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

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Please indicate if you have experienced any of the following:

- [ ] *Premedicate
- [ ] Allergies, Seasonal
- [ ] Allergy Amoxicillin
- [ ] Allergy Anesthetic
- [ ] Allergy Aspirin
- [ ] Allergy Codeine
- [ ] Allergy Erythromycin
- [ ] Allergy Iodine
- [ ] Allergy Latex
- [ ] Allergy Penicillin
- [ ] Allergy Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Do Not Use Epi
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Headaches
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Valve Defect
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Meds-see full med hx
- [ ] Mental Disorders
- [ ] Mitral ValveProlapse
- [ ] Nervous Disorders
- [ ] Nitroglycin
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

If any of the previous questions are marked, please explain:

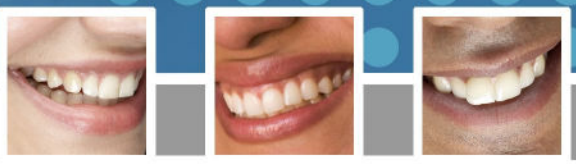
Do you have any other health issues or allergies?

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

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What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office) and what treatment did you receive?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

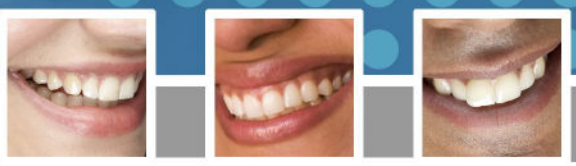
☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If you could change anything about your mouth, teeth, or smile, what would it be?

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

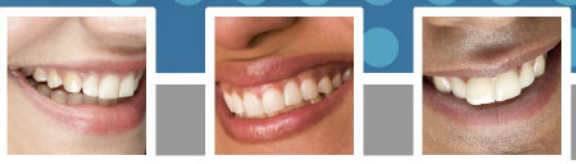
I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Relationship to Patient:

Response Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse To Sign This Acknowledgement**

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

I have been made aware that this office has a Notice of Privacy Practices. I understand, that upon my request, a copy of the Notice of Privacy Practices will be made available for my review.

I further authorize Dr. LeMonnier, and his staff, to disclose my Protected Health Information (PHI) in the following manner:

- ☐ Leave messages on my home and/or work answering machine.
- ☐ Leave messages with my family and/or others residing in my household.
- ☐ Discuss all aspects of my care with family or other individual as indicated below:

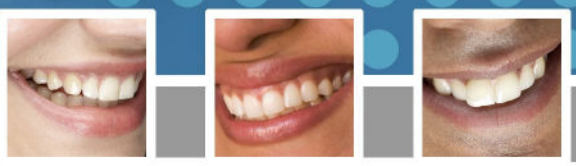
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining the acknowledgment.
- ☐ Other (Specify Below).

Response Date: _____

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FINANCIAL MENU

A) Prepay Courtesy

A prepayment courtesy of 5% (10% Senior Citizen, over 65) will be subtracted from the total patient obligation (not from any portion due from insurance company) if the patient obligation is paid in full at the first treatment visit. This option is available only if the total patient obligation is greater than $1,000.

B) Care Credit - Up to 12 Months Zero Interest Financing

With approval from Care Credit (a separate line of credit for health care services only), Dr. LeMonnier will pay the interest for up to 12 months. The application is very brief, and their response time is almost immediate. Note: Although they allow balances to carry beyond the specified time period, we urge you to pay it off during this time - on the first day of the month beyond the specified time period, you will be responsible for the interest, retroactive to the very first day of the loan. (Prepay Courtesy not eligible with Care Credit).

C) Three payments Zero Interest

Total patient obligation may be divided as follows: Three equal checks (or pre-signed credit card slips), post-dated for three consecutive months. Note: Balance payments will be written at the initiation of treatment, post-dated for 30 and 60 days. This option is available only if the total fee is greater than $500.

D) Pay as You Go

You may choose to pay your obligation for each visit, at the completion of each visit.

FORMS of PAYMENT and BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): Visa, MasterCard, American Express, Discover, Cash, Money Order, Personal Checks, or one of the financing options listed above. Balances >60 days will incur a finance charge of 18%APR, a fee will be incurred for returned checks, and the cost of third party collection may be added to your balance.

INSURANCE

It is our pleasure to assist you by completing your claim forms. If your carrier is up to date your claim will be transmitted electronically before the end of the treatment day! As a courtesy, in addition to filing the claim, we will initially ask you only for your estimated co-payment. Please understand that this is only an estimate, and is based upon the information you provide, as well as that available to us from your insurance carrier (to which we do not always have access).

The range of benefits depends solely on what your employer wishes to purchase. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, your actual percentage reimbursement may be lower than the level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Once your carrier has paid the claim, any difference will be due upon receipt of our statement. The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office. We will happily assist you in obtaining your benefits in any way that we can, however, we can not be responsible for denial of coverage by your insurance company.

By signing this I acknowledge that I understand my financial responsibility. Furthermore, I acknowledge that I am responsible for payment for all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

Response Date: _____