Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, don't hesitate to ask us- we will be happy to help!

Patient Information (CONFIDENTIAL)

Date: ____________

Name (First, Last): ____ Birthday: _________________ SSN: ____________________
Address: _______________________________________ City: _________________ State: _________ Zip Code: ______________
Home Phone: __________________________ Cell Phone: _________________________ Other: ____________________________
E-mail address: ____
Check Appropriate Box: ○Minor ○Single ○Married ○Divorced ○Widowed ○Separated
If Student, Name of School/College: ________________________ City: ________ State: _______ ○Full time ○Part Time
Patient or Parent/Guardian's Employer: __________________________________ Work Phone: _________________________
Business Address: ____ City: _____________ State: ___ Zip Code: __________
Spouse or Parent/Guardian's Name ____________________________ Employer: __________ Work Phone: _____________
Person to contact in case of emergency: ____ Phone: ___________________
How did you find about us? ○Google ○ Social Media ○Friend/Family

Responsible Party

Name of person responsible for this account: ___________________________ _ Relationship to Patient: _______________
Address: ___________________________ City: _____________ State:_____ Zip Code: ________ Phone: _____________________
E-mail: ____ Cell Phone: ____
Driver's License #: __________________________ Birthday: ________________ Financial Institution: ____________________
Employer: __________________________________ Work Phone: ______________________ SSN: ___________________________
Is this person currently a patient in our office? ○ Yes ○ No

Insurance Information

Name of Insured: ____________________________________ Relationship to Patient: ___________________________________
Birthday: _______________ SSN: _________________ Employer: ______________ Date Employed: _________________________
Address of Employer: ________________ City: _____________ State: _____ Zip Code: ________ Phone: ___________________
Insurance Company: ______________________________ Group#_____________ Policy/ID #: ______________________________
Ins. Co. Address: __________________________________ City: __________________ State: _________ Zip Code: ____________
How much is your deductible? ____________ Max annual benefit _______________ How much have you used? _________

Do you have additional insurance? ○Yes ○No If yes, complete the following:

Name of Insured: ____________________________________ Relationship to Patient: ___________________________________
Birthday: _______________ SSN: _________________ Employer: ______________ Date Employed: _________________________
Address of Employer: ________________ City: _____________ State: _____ Zip Code: ________ Phone: ___________________
Insurance Company: ______________________________ Group#_____________ Policy/ID #: ______________________________
Ins. Co. Address: __________________________________ City: __________________ State: _________ Zip Code: ____________
How much is your deductible? ____________ Max annual benefit _______________ How much have you used?_________

PATIENT DENTAL HISTORY

PATIENT'S NAME ______________________________ **DATE OF BIRTH** ____________________

REASON FOR THIS VISIT ______________________________

WHEN WAS YOUR LAST DENTAL VISIT ____________ WHAT WAS DONE THEN ____________________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN ____________________

PREVIOUS DENTIST (NAME AND LOCATION) ____________________

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE ____________________

HOW OFTEN DO YOU BRUSH YOUR TEETH ____________ HOW OFTEN DO YOU FLOSS YOUR TEETH ____________

IS YOUR DRINKING WATER FLUORIDATED YES ☐ NO ☐ What kind of water do you drink: City Well or Bottle (please circle)

	YES	NO
Do any of your teeth feel painful.......	☐	☐
Are your teeth sensitive to **hot or cold** liquids/foods..............................	☐	☐
Are your teeth sensitive to **sweet or sour** liquids/food...........................	☐	☐
Do your gums bleed while brushing or flossing?..................................	☐	☐
Have you ever had periodontal treatment (deep cleaning, gum graft, bone graft?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you experienced any of the following problems		
-Clicking in your jaw...	☐	☐
-Pain (joint, ear, side of face...	☐	☐
-Difficulty in opening or closing your jaw....	☐	☐
-Difficulty in chewing....	☐	☐
Do you have frequent headaches...........	☐	☐
Do you clench or grind your teeth..............	☐	☐

	YES	NO
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed any loosening of your teeth.........	☐	☐
Does food tend to become caught between your teeth....	☐	☐
Have you ever worn an occlusal guard or other appliance?	☐	☐
Do you wear dentures or partials?................	☐	☐
Do you have dental anxiety?	☐	☐
If so please explain your experience which caused the anxiety:		
Have you ever had any neck, head or jaw injury?	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

______________________________ ____________________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR **DATE**

______________________________ ____________________

MEDICAL HISTORY

Patient Name ______________________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ______	☐	☐
2.	an allergic reaction to ☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulfa ☐ local anesthetic ☐ fluoride ☐ metals (nickel, gold, silver, ________) ☐ Zythromycin (Z-Pack) ☐ other ______		
3.	heart problems, or cardiac stent within the last six months ___	☐	☐
4.	history of infective endocarditis ______	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6.	pacemaker or implantable defibrillator ______	☐	☐
7.	artificial prosthesis (heart valve or joints) ______	☐	☐
8.	rheumatic or scarlet fever ______	☐	☐
9.	high or low blood pressure ______	☐	☐
10.	a stroke (taking blood thinners) ______	☐	☐
11.	anemia or other blood disorder ______	☐	☐
12.	prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
13.	emphysema, shortness of breath, sarcoidosis ______	☐	☐
14.	tuberculosis, measles, chicken pox ______	☐	☐
15.	asthma ______	☐	☐
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17.	kidney disease ______	☐	☐
18.	liver disease ______	☐	☐
19.	jaundice ______	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21.	hormone deficiency ______	☐	☐
22.	high cholesterol or taking statin drugs ______	☐	☐
23.	diabetes (HbA1c =______) ______	☐	☐
24.	stomach or duodenal ulcer ______	☐	☐
25.	digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27.	arthritis, rheumatoid arthritis, lupus ______	☐	☐
28.	glaucoma ______	☐	☐
29.	contact lenses ______	☐	☐
30.	head or neck injuries ______	☐	☐
31.	epilepsy, convulsions (seizures) ______	☐	☐
32.	neurologic disorders (ADD/ADHD, prion disease) ______	☐	☐
33.	viral infections and cold sores ______	☐	☐
34.	any lumps or swelling in the mouth ______	☐	☐
35.	hives, skin rash, hay fever ______	☐	☐
36.	STI / STD ______	☐	☐
37.	hepatitis (type ___) ______	☐	☐
38.	HIV / AIDS ______	☐	☐
39.	tumor, abnormal growth ______	☐	☐
40.	radiation therapy ______	☐	☐
41.	chemotherapy, immunosuppressive ______	☐	☐
42.	emotional problems ______	☐	☐
43.	psychiatric treatment ______	☐	☐
44.	antidepressant medication ______	☐	☐
45.	alcohol / street drug use ______	☐	☐

ARE YOU:

		YES	NO
46.	presently being treated for any other illness ______	☐	☐
47.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
48.	taking medication for weight loss? (ex: Mounjaro, Wegovy)	☐	☐
49.	taking dietary supplements ______	☐	☐
50.	often exhausted or fatigued ______	☐	☐
51.	experiencing frequent headaches ______	☐	☐
52.	a smoker, smoked previously or use smokeless tobacco _	☐	☐
53.	a user of THC	☐	☐
54.	experiencing jaw pain or discomfort	☐	☐
55.	FEMALE - taking birth control pills ______	☐	☐
56.	FEMALE - pregnant ______	☐	☐
57.	MALE - prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ______________

MODERN DENTISTRY OF FREDERICK

Raheleh Makhmalbaf DMD

FINANCIAL POLICY

Thank you for choosing Modern Dentistry of Frederick as your dental Health Provider. We believe that all patients deserve the very best dental care we can provide.

Payment for services, including Deductibles and Co-insurance, are due at the time of the service. We accept payments using VISA, Mastercard, Discover, Cash, Check, HSA Cards or Care Credit.

We allow 30 days for the claim to be paid or denied as required by the Maryland Insurance Commission. Once payment, if any, has been received in our office, a billing statement will be sent for any uncovered balance. That balance is due within 30 days of the billing date. Balances unpaid after 30 days will be considered delinquent and subject to collection procedures. Any applicable fees or costs associated with the collection procedures will be added to the outstanding balance. In addition, at our office's discretion, existing appointments for that account may be cancelled.

For patients without insurance, full payment for that visit's services is due at the conclusion of that visit.

If insurance Pre-authorization estimate has been made, the entire portion is due at the beginning of that procedure. We cannot guarantee that any coverage estimate by your plan will be paid.

MODERN DENTISTRY of FREDERICK participates with some dental insurance plans. We are happy to submit the claim necessary. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges.

There will be a charge of $75.00 per missed appointment or any failure to show, including a canceled appointment less than 24 hour notice. Returned insufficient checks will result in an additional charge of $50.00 per check.

It is your responsibility to provide proof of insurance identification or any change of information since your last visit prior to incurring charges to your account.

Please indicate your understanding and acceptance of these financial policies by signing below.

Patient's Name:________________________________ Date:______________

Patient, Guardian or Guarantor Signature:____________________ Date:______________

Witness:________________________________ Date:______________

Ambers Professional Center • 174 Thomas Johnson Drive, #200 • Frederick, MD 21702
phone/ 301.695.9446 • fax/ 301.695.6170 • web/ www.ModernDentistryofFrederick.com

HIPAA Consent Form for Dental Practice (2026)

Modern Dentistry of Frederick
174 Thomas Johnson Drive Suite 200
Frederick, MD 21702
301-695-9446

Patient Name: ________________________________
Date of Birth: _______________________________
Phone Number: _______________________________
Email (optional): ____________________________

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review or receive a copy of this dental practice's *Notice of Privacy Practices*, which explains how my medical and dental information may be used and disclosed.

Consent for Use and Disclosure of Health Information

I understand that this dental practice may use and disclose my protected health information (PHI) for the following purposes:

Treatment: To provide, coordinate, or manage my dental care
Payment: To bill and collect payment from me, my insurance company, or a third party
Healthcare Operations: For administrative, quality assurance, and operational purposes

I understand that my information may be shared with:

Other healthcare providers involved in my care
Insurance companies and billing services
Business associates that assist in practice operations (in compliance with HIPAA regulations)

Patient Rights

I understand that I have the right to:

Request restrictions on certain uses and disclosures of my information
Request confidential communications
Inspect and obtain a copy of my health records
Request corrections to my health information
Receive an accounting of disclosures
Optional: Communication Preferences

Please indicate how you prefer to be contacted (check all that apply):

☐ Phone (call)
☐ Phone (text)
☐ Email
☐ Mail

May we leave voicemail messages? ☐ Yes ☐ No

Optional: Authorized Individuals

I authorize the following individuals to receive information about my dental care:

Name: __________________________ Relationship: __________________

Name: __________________________ Relationship: __________________

Right to Revoke

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken based on this consent.

Acknowledgment and Signature

I have read and understand this HIPAA Consent Form. I consent to the use and disclosure of my protected health information as described above.

Patient/Guardian Name (print): ______________________________
Signature: ____
Date: ____________________

For Office Use Only

Date Acknowledgment Received: __________________
If not obtained, reason: ______________________________________