

ROCHELLE E. HACKLEY DDS, LLC & DENTAL SPA  
*WE CATER TO COWARDS*

WELCOME TO OUR PRACTICE

12230 Rockville Pike, Suite 200-B  
Rockville, MD 20852  
301-816-3232

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name) Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Cell: \_\_\_\_\_ Send txt for appointment reminders: yes \_\_\_\_\_ no \_\_\_\_\_  
E-mail \_\_\_\_\_ Send E-mail for correspondence: yes \_\_\_\_\_ no \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City  
State Zip Code  
In Case of Emergency: Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office \_\_\_\_\_  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
NAME OF OFFICE  
Name of person or office referring you to our practice: \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

## Employment Information

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

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Phone

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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.

**If you cannot keep your appointment, please provide at least 48 hours advance notice or you may be charged a cancellation fee.**

I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**HEALTH HISTORY**

**HEALTH INFORMATION**

PLEASE PRINT

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

If completing this form for another person, what is your name and relationship to that person?  
 \_\_\_\_\_

Is there anything you wish to discuss in private with the doctor? Yes \_\_\_\_\_ No \_\_\_\_\_

For the following questions, circle Yes or No. Your answers are for our records only and will be kept confidential.

- |   |     |    |   |     |    |
|---|-----|----|---|-----|----|
| 1. Are you in good health? .....  | Yes | No | 29. TB, Tuberculosis (Self, Family, Household) .....                      | Yes | No |
| 2. Has there been any change in your general health within the past year? ..... | Yes | No | 30. Persistent cough/ cough that produces blood .....                     | Yes | No |
| <b>Have you ever had or do you now have?</b>                                    |     |    | 31. Arthritis or painful/swollen joints .....                             | Yes | No |
| 3. Pacemaker .....  | Yes | No | 32. Artificial joint replacement .....                                    | Yes | No |
| 4. Heart Murmur .....   | Yes | No | 33. Stomach ulcer or hyperacidity .....                                   | Yes | No |
| 5. Mitral valve prolapse .....  | Yes | No | 34. Kidney trouble or dialysis .....                                      | Yes | No |
| 6. Rheumatic heart disease .....  | Yes | No | 35. Persistent swollen glands in neck .....                               | Yes | No |
| 7. Damaged heart valve .....  | Yes | No | 36. Sexually transmitted disease .....                                    | Yes | No |
| 8. Heart trouble .....  | Yes | No | 37. Epilepsy or other neurological disease .....                          | Yes | No |
| 9. Heart attack .....   | Yes | No | 38. Psychotherapy .....   | Yes | No |
| 10. Angina .....  | Yes | No | 39. Problems with mental health .....                                     | Yes | No |
| 11. High Blood Pressure .....   | Yes | No | 40. Cancer .....  | Yes | No |
| 12. Arteriosclerosis (hardening of the arteries) .....                          | Yes | No | 41. Problems of the immune system .....                                   | Yes | No |
| 13. Stroke .....  | Yes | No | 42. Rheumatic fever or scarlet fever .....                                | Yes | No |
| 14. Chest pain upon exertion .....  | Yes | No | 43. Abnormal bleeding .....   | Yes | No |
| 15. Shortness of breath after mild exercise or when lying down? .....           | Yes | No | 44. Blood transfusion .....   | Yes | No |
| 16. Swollen ankles .....  | Yes | No | 45. Blood disorders such as anemia .....                                  | Yes | No |
| 17. Congenital heart defect .....   | Yes | No | 46. Tumor or growth .....   | Yes | No |
| 18. Prosthetic (artificial) heart valve .....                                   | Yes | No | 47. Allergic or other reaction to   |     |    |
| 19. Allergy .....   | Yes | No | a. local anesthetics or dental anesthetics ....                           | Yes | No |
| 20. Sinus trouble .....   | Yes | No | b. Penicillin or other antibiotics .....                                  | Yes | No |
| 21. Asthma or hay fever .....   | Yes | No | c. Sulfa drugs .....  | Yes | No |
| 22. Fainting spells or seizures .....   | Yes | No | d. Barbiturates, sedatives, or sleeping pills ...                         | Yes | No |
| 23. Persistent diarrhea or recent weight loss .....                             | Yes | No | e. Aspirin .....  | Yes | No |
| 24. Diabetes .....  | Yes | No | f. Codeine .....  | Yes | No |
| 25. Hepatitis, jaundice or liver disease .....                                  | Yes | No | g. Other .....  | Yes | No |
| 26. AIDS or HIV infection .....   | Yes | No | <b>Women</b>  |     |    |
| 27. Thyroid problems .....  | Yes | No | 48. Are you pregnant? .....   | Yes | No |
| 28. Respiratory problems, emphysema, bronchitis, etc. ....                      | Yes | No | 49. Do you have any problems associated with your menstrual period? ..... | Yes | No |
|   |     |    | 50. Are you nursing? .....  | Yes | No |

Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:  
 \_\_\_\_\_

Are you taking any medications (including non prescription)? \_\_\_\_\_

Tobacco use: Current Past Never used Type \_\_\_\_\_ Amount per day \_\_\_\_\_ Date tobacco use stopped \_\_\_\_\_

Alcohol use: Current Past Never used Describe usage: \_\_\_\_\_

Names of your primary health care practitioners (MD, DC, DO, etc.):

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?  
 \_\_\_\_\_

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Date \_\_\_\_\_

# Rochelle E. Hackley DDS LLC, Dental Spa

12230 Rockville Pike, Suite 200-B

Rockville, MD 20852

Phone: (301) 816-3232 Fax: (301) 816-7869

## DENTAL HISTORY

Thank you for selecting our dental healthcare team. Please respond to the following dental history questionnaire, designed to open a discussion of your dental concerns. Should you need assistance, we are glad to help.

Your current dental health is:            Good                      Fair                      Poor

Describe your current dental problem(s) or concern(s):  
\_\_\_\_\_

When was your last dental hygiene appointment? \_\_\_\_\_

What dental aids do you use?            Electric toothbrush            toothpicks            proxibrushes

Yes    No    Have you ever had root planing (deep cleaning) done?

Yes    No    Have you been experiencing pain or discomfort related to your teeth, gums or jaw joints?

Yes    No    Do you have a bite plate or mouth guard?

Yes    No    Have you had clicking, popping or pain in your jaw joint or muscles?

Yes    No    Have you noticed any mouth odors (halitosis) or bad tastes?

Yes    No    Are your gums red, swollen, glossy or tender?

Yes    No    Do your gums bleed or hurt?

Yes    No    Have your parents ever experienced gum disease or tooth loss?

Yes    No    Do you frequently experience cold sores, blisters or any other oral lesions?

Yes    No    Have you noticed any loose teeth?

Yes    No    Have you noticed a change in your bite?

Yes    No    Do you clench or grind your teeth while awake or asleep?

Yes    No    Have you experienced a serious injury to the mouth or head?

Yes    No    Would you like to keep your natural teeth for as long as you live?

Yes    No    Do you get frustrated that you need work done every time you go to the dentist?

Yes    No    Are you satisfied with your teeth's appearance?

Yes    No    Would you like to have whiter teeth?

Yes    No    Would you like your teeth to be straighter?

Yes    No    Do you have metal or discolored fillings that you are unhappy with?

Yes    No    Do you have crowns or bridges that are unattractive or unnatural-looking?

Yes    No    Do you sometimes feel uncomfortable with the appearance of your smile?

Yes    No    Do you have unattractive spaces between your teeth?

Yes    No    Do you experience headaches, neckaches or shoulder aches?

Yes    No    Do you have difficulty opening or closing your mouth?

Yes    No    Have you ever had periodontal treatment?

Yes    No    Are you apprehensive about dental treatment? If so, what are concerns?

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Handle Me With Care

- I gag easily.
- I feel out of control when I am lying down in the dental chair.
- I have not been to the dentist for a long time and I feel uncomfortable about what will say or think about my teeth and my dental hygiene.
- I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- Pain relief is a top priority to me.
- I don't like shots, or I've had a bad reaction to shots.
- Please tell me what I need to know about my mouth so I can make an informed decision.
- My teeth are very sensitive.
- I don't like the sound of that tool that makes the picking and scraping noise.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- I don't like the dental office smells.
- Please respect my time. I don't want to be left sitting in the reception area.
- I want to know the cost up front. No money surprises, please.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.
- I don't like being left alone in the treatment area.
- I have problems with my back.
- I don't like the chair tipped back too far.
- I do not like to see dental instruments.
- I need to talk to you first, without sitting in the dental chair.
- Other concerns I would like to talk about (Please specify):

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# Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

## Payment options:

1. Cash
2. CareCredit
3. MasterCard
4. Visa
5. Discover
6. American Express
6. Credit card authorization for recurring charges:
  - a. Invisalign Monthly Payment
  - b. Major Services Broken into 3 payments 2 weeks apart

**Patient with insurance:** The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, and any balance remaining AFTER insurance payment. If the insurance company does not pay after 90 days, we will bill you directly for the full balance.

**Parents not accompanying their child** to an appointment must make PRIOR arrangements for payment (cash or credit card authorization).

**Parents accompanying their children** are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A \$15 fee is charged for nonpayment.

There is a \$30.00 processing charge for **non-sufficient funds** or returned checks.

Billing Fee \$5 will be incurred if balance is not paid at time of service.

**Records** can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **\$25 - \$100 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, \_\_\_\_\_, agree to these financial terms.

Signature	PREFERRED NAME TO BE CALLED	TODAY'S DATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Date	MIDDLE		