Chart # _____

Lev Tomashevsky DDS LLC
Robert J. Kelly DDS & Associates

832 Quince Orchard Blvd
Gaithersburg, MD 20878
(301) 948-0058

220 Main Street
Gaithersburg, MD 20878
(301) 519-3232

10339 Kensington Parkway
Kensington, MD 20895
(301) 949-2280

Mission Statement

"My associates and I are sincerely committed to providing you with the most advanced dental techniques and pain-free treatments in a friendly and comfortable environment."

Patient Information

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Name as on Insurance: _____

Sex: Male Female Marital Status: _____

Birth Date: _____/ _____/ _____ SSN: _____-_____-_____(*Required for insurance claims)

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: (_____) _____ Cell #: (_____)_____

Work#: (_____) _____ E-mail: _____

Employer: _____ Occupation: _____

Employer Address: _____

Accounting Information

- If same as above please check here ☐ ; If not, please fill out the following

Relationship to Patient: _____

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____/ _____/ _____ SSN: _____ - _____ -_____

Drivers License #: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: (_____) _____ Cell#: (_____) _____

Employer: _____ Work#: (_____) _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Insurance Company Name: _____ Insurance Phone #: (_____) _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Group Number: _____

Employer of Policy Holder: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____/ _____ / _____ Policy Holder SSN: _____ - _____ - _____

Emergency Contact Information

Whom may we contact in case of a medical emergency?

Name: _____ Phone: (____) _____
Relation to Self: _____

Dental History

Reason for today's visit: _____

When did you last see a dentist? Month _____ Year: _____

Treatment Received: _____

Were X-rays Taken? _____ Type of X-rays? _____

How often do you normally visit a dentist? _____

Have you had any problems associated with past dental treatment? ☐ Yes ☐ No **If yes, please explain**:

_____

How would you rate your present oral health? ☐ Good ☐ Fair ☐ Poor

Medical History

In order to provide you with the best possible dental care, it is necessary that we know as much about your medical history as possible prior to treatment.

Circle the appropriate answers below:

Are you currently under the care of a physician?	Y	N
Name of Physician: Phone #: ( ) -		
Have you had any recent illness or surgery?	Y	N
If yes, please explain:		
Have you been hospitalized in the last 5 years?	Y	N
If yes, for what?		
Are you suffering from abuse/neglect?	Y	N
Are you taking any drugs, medicines or herbal supplements?	Y	N
If yes, please list:		
Are you allergic to any food or drug?	Y	N
If yes, please specify:		

Have you had …

Any unusual reaction to local anesthetic	Y	N
Sleep Apnea	Y	N
Heart Problems	Y	N
High Blood Pressure	Y	N
Stroke/TIA	Y	N
Nervous System Disorders (i.e. Seizures, MS, Bell's Palsy)	Y	N
Blood Disorders (i.e. Anemia, Delay in clotting, Increased clotting)	Y	N
Diabetes (Type I or II)	Y	N
Hepatitis or Liver Disease	Y	N
Venereal Disease (i.e. herpes, syphilis, gonorrhea, HPV)	Y	N
HIV or AIDS	Y	N
Tuberculosis or Positive TB test	Y	N
Kidney or Urinary Problems	Y	N
Cancer or Tumor	Y	N
Radiation Therapy	Y	N
Digestive Disorders (i.e. GERD, ulcers, colitis, IBS, Chron's, Celiac)	Y	N
Lyme Disease	Y	N
Rheumatory Diseases (i.e. Lupus, RA, Sjogren's)	Y	N
Breathing Problems (i.e. Asthma, COPD)	Y	N
Osteoporosis/Osteopenia	Y	N
Dizziness or Fainting	Y	N
Frequent Headaches	Y	N
For Women:	Y	N
Are you pregnant?	Y	N
Are you taking birth control pills?	Y	N
Are you under estrogen replacement therapy?	Y	N
Any Tobacco Habits?	Y	N
If yes, type and amount per day:		
Any additional information about your health not covered above?	Y	N

Payment Agreement

The Undersigned agrees to pay for any interest on overdue accounts, collection fees, and/or reasonable legal fees (if legal action is required for the collection of this account) necessary in the management of any credit extensions with Lev Tomashevsky DDS LLC DBA Robert J. Kelly, D.D.S. and Associates.

Signed: _____ Date: _____/ _____/ _____

Important Office Policies

I. Appointment Scheduling Policy

All dental appointments, once scheduled, are considered reserved and confirmed. We will give you a courtesy reminder call or leave a message on your answering machine 2-3 days prior to your dental appointment. This call serves as a **courtesy** reminder of your appointment. However, it is ultimately your responsibility to be here as scheduled. If you cannot make your appointment, we expect no less than 24 hours notice. Please note: a charge of $50.00 per patient will be applied to your account, for appointments broken without a full 24 hours notice. This policy is applies to existing and new patients. The policy is necessary due to the increasing number of patients canceling or failing their appointments. We can no longer give our patients this luxury.

II. Methods of Payment

Your chosen payment method must be established with the receptionist before the start of any treatment. All charges from the date of service are your responsibility. Please review the below options for methods of payment. A copy of your insurance identification card and drivers license is needed for all credit arrangements.

-Dental Insurance: Please provide all insurance information as requested on this form. Refer to *Section III—"Dental Insurance Policies"* for further detailed information.

-Cash

-Check: We will be happy to accept your check provided that you are able to show us your current Drivers License or other equivalent State issued ID.

-Credit Cards: Visa, MasterCard, Discover and American express are accepted.

-CareCredit Financial Plan: Financing options are available through CareCredit. If approved, they offer up to a 12-month interest-free payment plan. Please contact our financial coordinators for more details.

-CitiHealth Financial Plan: Financing options are available through CitiHealth. If approved, they offer 18-24-month interest-free payment plans. Please contact our financial coordinators for more details.

-In House Payment Plan: A minimum of 50% of the treatment costs is required to institute this plan and the remainder is payable in equal monthly installments, the total must be paid within 90 days with 1% interest accrued monthly. Please refer to Payment options pamphlet provided in your New Patient Folder.

-Please note that returned checks and balances older than 60 days will be subject to additional collections fees and interest charges of 1% per month. Also, please note that any uncollected balance that is turned over to court will be subject to reasonable lawyer fees and interest. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at (240) 243-0500.

III. Dental Insurance Policies

We must emphasize that as dental care providers our relationship is with you, not that of your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. fees. "UCR" is defined as usual, customary and reasonable by most insurance companies. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

All charges from services rendered are your responsibility. Your co-pay and deductible are expected at the time of service. The co-pay is based on the estimated patient responsibility percentage of the UCR fee (as provided to us by your insurance company). Once payment by insurance is received, charges may differ according to insurance contract and coverage. We submit to all primary dental insurance claims as a courtesy extended to our patients. We will gladly provide a reasonable amount of information requested by insurance for the claims and pre-treatment estimates at no charge. Your insurance company has 30 days by Maryland law to approve or deny each received claim.

Your monthly statement will show whether or not insurance has paid a claim. We add finance charges to your account after 60 days, whether your insurance has paid or not. For those with more than a single insurance coverage, it is our policy to file only the claims for the insurance that is considered to be the primary carrier. The receptionist will provide you with a walk out statement at the end of each appointment. The statement will list all services rendered that day. You may use this to check on the status of your claim, as we cannot afford to follow up on each claim we submit. The average "hold" time we experience when calling insurance to check claim status, is 2 to 20 minutes.

As a Preferred Provider Organization (PPO) participant, our office must accept 20% to 30% less than our usual and customary fees in order to participate in these insurance plans. Please note that although we will continue to file claims at no charge to you, there will be a **minimum of $25.00 fee for every claim we are asked to research and/or re-file**.

IV. Agreement and Authorization

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I hereby Authorize (A) Lev Tomashevsky DDS LLC DBA Robert J. Kelly DDS and Associates, to release information necessary to my insurance carrier(s) concerning the dental treatment for me or my dependents (B) authorize payment of all dental insurance benefits for services rendered to be paid to Lev Tomashevsky DDS LLC DBA Robert J. Kelly DDS and Associates, (C) A Photostat of this authorization shall be valid as an original. I understand that I am responsible for any balance determined by my insurance carrier to be the patient's responsibility and for any services that are not a covered expense by that company. My below signature affirms that I have read and agree to the above terms.

Name of Patient/ Guardian (Please Print): _____

Signature of Patient/ Guardian: _____ Date: ____/ ____/ ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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

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

_____

_____ Receptionist Initials: _____

WHO MAY WE THANK?

Thank you for choosing Lev Tomashevsky DDS LLC DBA Robert J. Kelly DDS & Associates for your dental needs. We are grateful for your confidence in us and will strive to serve you and your family with the highest level of service possible.

Please tell us how you heard about our practice:

- ☐ Patient referral – Patient's Name: _____
- ☐ Insurance Company
- ☐ Doctors referral – Doctor's Name: _____
- ☐ Google search
- ☐ Other internet search engine - Please specify: _____
- ☐ The Gazette
- ☐ Yelp
- ☐ Russian yellow pages
- ☐ Walk in/ Live in area
- ☐ Rainbow Adult Care Center
- ☐ Washingtonian Parent Magazine
- ☐ Better Business Bureau
- ☐ TV/Radio advertisement
- ☐ Other: _____

As a way of thanking you, we will credit you and your referrals $25.00 for each patient you refer to our practice.