# Felicia M. Nesbit, D.D.S., P.C. -- Welcome To Our Office

956 Chandler Court, Waldorf, Maryland 20602 phone: 301.705.9737 fax: 301.893.2194

Today's Date: _____ Patient #: _____

**PATIENT INFORMATION:**

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr.
Name: _____
Address: _____
City/ State/ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email address: _____
Birth date: _____ Age: _____
SS#: _____
☐ Male ☐ Female ☐ Single
☐ Married ☐ Widowed ☐ Separated
☐ Divorced

**EMPLOYMENT INFORMATION:**

Employer: _____
Work #: _____
Occupation: _____
**Referred by:** _____

**DENTAL INSURANCE:**

Insurance Company: _____
Address: _____
City/ State/ Zip: _____
Phone #: _____
Insured's Employer: _____
Insured's Name: _____
Relationship to patient: _____
Insured's SS# or Mem. #: _____
Insured's Date of Birth: _____
Policy/ Group #: _____

**HEALTH/ MEDICAL INSURANCE:**

Insurance Company: _____
Address: _____
City/ State/ Zip: _____
Phone #: _____
Policy/ Group #: _____

Insured's Name: _____
Insured's Employer: _____
Relationship to patient: _____
Insured's SS# or Mem. #: _____
Insured's Date of Birth: _____

## Please check all dental concerns that apply to you:

**Teeth:**

☐ Broken or Chipped
☐ Cracked
☐ Decay
☐ Difficulty Chewing
☐ Discolored
☐ Food Trap Areas
☐ Grinding or clenching
☐ Loose or missing fillings
☐ Loose Tooth or Teeth
☐ Missing tooth or teeth
☐ Mouth sores
☐ Sensitive to sweets
☐ Sensitive to temperature changes
☐ Tooth pain

**Gums:**

☐ Bleeding
☐ Pimple or Bump
☐ Sore or Sensitive

**Jaw / Facial Pain:**

☐ Facial Pain ☐ Frequent Headaches
☐ Jaw Clicks ☐ Jaw Pain
☐ Pain in cheeks or temples

**Past dental History:** last dental visit: _____ Dental visit frequency: ____Months ____Years ___As needed
☐ Have tooth replacements such as dentures, partials, bridges or implants? **Other:** _____

## List Any Medications Which Have Caused an Allergic Reaction:

☐ Y ☐ N Antibiotics
such as (Clindamycin, Penicillin, and Sulfa drugs)
☐ Y ☐ N Aspirin
☐ Y ☐ N Codeine
☐ Y ☐ N Iodine
☐ Y ☐ N Latex/ Rubber
other allergens: _____

☐ Y ☐ N Local Anesthetics
☐ Y ☐ N Metal
☐ Y ☐ N Novacaine
☐ Y ☐ N Plastic
☐ Y ☐ N Sedatives
☐ Y ☐ N Sleeping pills

## List of Any Medications You Are Currently Taking:

☐ Y ☐ N Antibiotics
☐ Y ☐ N Anticoagulants
☐ Y ☐ N Blood Thinners
☐ Y ☐ N Blood Pressure
☐ Y ☐ N Diet Pills
☐ Y ☐ N Pain Medication
☐ Y ☐ N Cortisone
☐ Y ☐ N Digestive Aids
☐ Y ☐ N Heart Medication
☐ Y ☐ N Insulin
☐ Y ☐ N Muscle relaxants
☐ Y ☐ N Codeine
☐ Y ☐ N Sleeping Pills
☐ Y ☐ N Tranquilizers

**Please include non- prescription medicine:** _____
**Name of other medications you are taking?** _____

## Medical History & Conditions:

Are you in good health? ☐ Y ☐ N
Do you bruise easily? ☐ Y ☐ N
Have you had a recent weight loss? ☐ Y ☐ N
Have you ever taken Actonel, Fosamax, Boniva? ☐ Y ☐ N
Do you use tobacco? ☐ Y ☐ N
Are you wearing contact lenses? ☐ Y ☐ N
Have you ever had abnormal bleeding? ☐ Y ☐ N
Have you ever required a blood transfusion? ☐ Y ☐ N
Have you ever take Fen- Phen/ Redux? ☐ Y ☐ N
Do you use controlled substances? ☐ Y ☐ N
Do you have a persistent cough? ☐ Y ☐ N
(lasting longer than 3 weeks)
Have you taken Viagra, Revatio, Cialis, or Lavitrain the last 24 hours? ☐ Y ☐ N

☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis
☐ Y ☐ N Artificial Joint or Prosthetic
☐ Y ☐ N Asthma
☐ Y ☐ N Bleeding Easily after a cut
☐ Y ☐ N Cancer
☐ Y ☐ N Chronic mouth dryness
☐ Y ☐ N Current pregnancy
☐ Y ☐ N Depression
☐ Y ☐ N Diabetes
☐ Y ☐ N Digestive Problems
☐ Y ☐ N Dizziness
☐ Y ☐ N Epilepsy
☐ Y ☐ N Headaches
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Pacemaker
☐ Y ☐ N Heart Palpitations
☐ Y ☐ N Heart Valve Replacement
☐ Y ☐ N Heart Valve Damaged
☐ Y ☐ N Hepatitis
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N HIV
☐ Y ☐ N Immune System Disorder (i.e. A.I.D.S.)
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Liver Problems
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Radiation
☐ Y ☐ N Respiratory Problems
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Tuberculosis

Other medical history: _____

## Describe Any Serious Illness, Major Surgery or Conditions Not Listed On Previous Page

Date Description

_____ _____

## Are you under a Physician's Care?

Practitioner Specialty Treatment & Approximate Date

_____ _____ _____

**Primary Care Physician:** _____ **Tel. #:** _____

If this visit is due to an accident please describe: _____

**Consent:** I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or legal documentation. I understand that I responsible for all fees for treatment regardless of insurance carrier and coverage.

**Patient Signature:** _____ **Date:** _____

# NESBIT CENTER OF DENTAL EXCELLENCE

## FINANCIAL POLICY/AGREEMENT

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 services. This office will help prepare the patients insurance forms or assist in making collections for insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If an insurance company has not paid after thirty (30) days the balance is the patient's responsibility.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30days unless previously written financial arrangements are satisfied.

If an appointment cannot be kept we require twenty four (24) hours notice. This courtesy makes it possible to give your appointment to another patient. We reserve the right to apply a twenty five dollar ($25.00) per hour cancellation fee for broken and or missed appointments with less than a twenty four hour notice.

All insufficient funds must be paid within five (5) working days with cash or certified funds. We reserve the right to charge a twenty five dollar ($25.00) fee.

I understand that the fee estimate listed for this dental care can only be extended for a period of ninety (90) days from the date of examination.

In consideration for the professional services rendered by the Doctor, I agree to pay the Doctor or her associate at the time services are rendered or according to any agreed upon financial arrangements. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of further term or condition.

In addition, should my account be placed for outside collections I agree to all costs of collection including but not limited to: collection agency fees of 30%, court costs attorney fees, etc.

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 financial policy/ agreement and agree to it's content.

Patient or guardian _____ Date: _____

Relationship to Patient: _____

Dr. Felicia Nesbit
956 Chandler Ct
Waldorf, MD 20602
(301) 705-9737

# Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

> *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of disease."*

A vitamin is not a drug, Neither is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a vitamin, a mineral, Trace, Element, Amino Acid, or Herb, may have an effect on any disease process or symptoms, this does not mean that it can be misinterpreted, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

I have read and understood the above:

Signature: _____

Date: _____