INNA KOST D.M.D. , M.Sc.
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(301) 530-6195

WELCOME TO BETHESDA PRACTICE!

PATIENT INFORMATION

TODAY'S DATE: _____

Patient Name: _____

Patient's Address: _____

_____

_____

Patient's Age: _____ Sex: _____

Patient's Date of Birth: _____

Patient's Social Security #: _____

Patient's Phone #: _____

Cell Phone #: _____

Marital Status: _____

INSURANCE INFORMATION

Name of Insured: _____

Address: _____

_____

Employer: _____

Address: _____

_____

Insurance Company: _____

Address: _____

_____

Relationship to Patient: _____

Date of Birth: _____

Social Security #: _____

Phone: _____

Union or Local #: _____

Group #: _____

Phone #: _____

Member #: _____

Family / Single Coverage: _____

ADDITIONAL INSURANCE

Name of Insured: _____

Employer: _____

Insurance Company: _____

Address: _____

_____

Relationship to Patient: _____

Social Security #: _____

Date of Birth: _____

Phone: _____

Group #: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

- ❑ Insurance
- ❑ Internet Search
- ❑ Family / Friend _____ *name*
- ❑ Printed Ad _____ *publication*
- ❑ Other _____ *please specify*

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PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____

Have you ever been told you have one of the following? Check only if answer is yes.

___ Heart Disease	___ Anemia	___ Asthma
___ Heart Attack	___ Bleeds Easily	___ Shortness of Breath
___ Heart Murmur	___ Fainting/Seizures	___ Swollen Ankles
___ Chest Pain –Angina	___ Epilepsy/ Convulsions	___ Hay Fever/Allergies
___ Congenital Heart Defect	___ Arthritis	___ Emphysema
___ Rheumatic Fever	___ Joint Replacement/Implant	___ Recent Weight Loss
___ High Blood Pressure	___ Liver Disease	___ Diabetes
___ Low Blood Pressure	___ Hepatitis	___ Cancer
___ Stroke	___ Jaundice	___ Radiation Therapy
___Thyroid Disease	___ Glaucoma	___ Psychiatric Treatment
___ Stomach Ulcer	___ Leukemia	___ Other _____
___ Mitral Valve Prolapse	___ AIDS/HIV	_____
___ Sexually Transmitted Disease	___ Kidney Disease	_____

Yes NO

___ ___ 1. Are you under medical treatment now? Why: _____
___ ___ 2. Have you ever had any other serious illness not listed above? What: _____
___ ___ 3. Are you currently taking any medications? What: _____
___ ___ 4. Have you ever had a bad reaction to local anesthetic or penicillin? What: _____
___ ___ 5. Do you use tobacco? _____
___ ___ 6. Do you use Alcohol, Cocaine or other drugs? What: _____
___ ___ 7. Women Only: Are you pregnant or think you may be pregnant? What month:_____
Are you taking birth control pills? _____

PATIENT DENTAL HISTORY

What is your reason for seeking care at this time: _____
Do you have regular dental checkups? When was your last dental exam: _____
Do you have any pain or discomfort now? What: _____
Do your gums bleed? _____ Have you had surgery preformed on your gums? _____
Have you ever had a root canal? _____ Have you ever worn braces? _____ Do you wear Dentures?_____
Do you grind your teeth?_____ Have you ever had any trauma to your face or mouth? _____
Do you floss? How often? _____ How many times a day do you brush your teeth? _____

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 also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

_____ Date: _____
Signature of Patient/Parent or Guardian