RALPH W ALMAN, JR, DDS, PA

Dental Implants ✦ Oral Maxillofacial Surgery

PATIENT REGISTRATION FORM

Patient Information: DATE: ____________

Last Name: ____ Title (Dr, Rev, etc.):____________

First Name: ________________________ Middle Initial: _______ Date of Birth: __________ Age: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Email Address: ____ Please check the best number to reach you.

Street Address: ____ Mobile ☐mom ☐dad #:☐ ______________

City: ____ Work ☐mom ☐dad #:☐ ______________

State: ☐ MD ☐ DC ☐VA Other: _____ Zip/Code: __________ Home #:☐ ______________

Employment: ☐ Employed ☐ Retired ☐ Self-Employed Other #: ________________ :☐ ______________

Occupation: ______________________________ Employer: ______________________________

If Student, School Attending: ______________________________

Have you ever been a patient of Dr. Alman? ☐ Yes ☐ No

Has anyone in your family been a patient of Dr. Alman? ☐ Yes ☐ No ______________________________

Referral Information: Who referred to our office? ☐ Dentist ☐ Family ☐ Friend ☐ Other

Name of General/Restorative Dentist: ____

And/Or Dental Specialist: ☐ Prosthodontist ☐ Endodontist ☐ Orthodontist ☐ Pediodontist ☐ Periodontist

Name of Dental Specialist: ____

Referred by Friend/Family/Other: ____

Dental Insurance & Payment: ☐No Dental Insurance Dental Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Most oral surgery procedures are covered by dental insurance. Occasionally, we are able to submit to your medical insurance. Please discuss this with the staff before providing medical insurance information.

Please show your insurance card to assist assuring that the correct information is submitted:

Policy Holder Name: ________________________ Date of Birth: __________ ID #: ____________________

Policy Holder Address: ☐ Same ____

DENTAL Insurance Name: ______________________________

DENTAL Insurance Address: ____

As an additional service, we are pleased to file to your dental insurance for you to be reimbursed.

☐ I acknowledge that Dr. Alman does not participate with any insurance plans as a preferred provider.

☐ I authorize the release of information (X-rays & contacting my referring dentist) as necessary.

Today's Fees Will Be Paid By: ☐ Cash ☐ Check ☐ Credit Card (VISA, MC, or Discover - We do not accept AMEX)

Privacy & Patient Acknowledgements:

☐ I acknowledge that I have been given the right to review the Notice of Privacy Practices for this office (HIPAA).

☐ I have read and understand this entire form. I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand that this information is necessary to provide dental care in a safe and efficient manner. I will not hold Ralph W Alman, Jr, DDS, PA or the staff responsible for any errors or omissions that I have made in the completion of this form.

☐ I understand that I am responsible for all costs of this treatment, including all collection fees, interest of 1½% from the original date of treatment, attorney fees, & court fees. Returned checks are subject to a $50 fee.

____ __________

Signature (☐ Patient ☐ Parent ☐ Legal Guardian ☐ Medical Surrogate) Date:

RALPH W ALMAN, JR, DDS, PA

Dental Implants ✦ Oral Maxillofacial Surgery **Date:** ___________

HEALTH HISTORY FORM – page 1 of 2

GENERAL HEALTH: Height: __________ Weight: ___________

☐Y ☐N Do you see a medical doctor for any reason other than annual routine visits?
☐Y ☐N Are you under the care of a physician? Name: ________________________ #:_________________
☐Y ☐N Have you had an illness, operation, or been hospitalized in the past 5 years? ___________________
☐Y ☐N Do you need to take antibiotics prior to having dental care?
Please provide your Pharmacy Name & #: ____

CONDITIONS: For each Yes please note beside or at the bottom line any details.

HEART & CIRCULATORY:

☐Y ☐N High/Low Blood Pressure	☐Y ☐N Heart Surgery
☐Y ☐N Blood Transfusion	☐Y ☐N Heart Murmur/ Mitral Valve Prolapse
☐Y ☐N Cardiac Pacemaker	☐Y ☐N Heart Valve Problem
☐Y ☐N Chest Pain / Angina	☐Y ☐N Bleeding Tendency / Abnormal Bleeding
☐Y ☐N Irregular Heartbeat	☐Y ☐N Frequent Nosebleeds
☐Y ☐N Heart Attack(s)	☐Y ☐N Blood Disorder Such As Anemia (any kind)
☐Y ☐N Bruise Easily	☐Y ☐N HIV-positive / AIDS / Hepatitis
☐Y ☐N Artificial Heart Valve	☐Y ☐N Rheumatic Fever

RESPIRATORY:

☐Y ☐N Asthma	☐Y ☐N Smoke ☐ Past ☐ Current __ Pk/Day or ☐ Other Products
☐Y ☐N Shortness of Breath	☐Y ☐N Bronchitis / Chronic Cough / Emphysema
☐Y ☐N Sleep Apnea	☐Y ☐N Hay Fever / Sinus Problems
☐Y ☐N Tuberculosis /Other Lung Diseases	☐Y ☐N Difficult Breathing/ Other Lung Problems

OTHER:

☐Y ☐N History of Drug or Alcohol Abuse	☐Y ☐N Thyroid Problems
☐Y ☐N Immune System Problems	☐Y ☐N Swollen Ankles, Arthritis, or Joint Disease
☐Y ☐N Difficulty Opening Mouth	☐Y ☐N Chronic Fatigue / Night Sweats
☐Y ☐N Sexually Transmitted Diseases	☐Y ☐N Fainting / Convulsions / Epilepsy / Seizures
☐Y ☐N Stroke(s)/Neurological Disease	☐Y ☐N Eye Disease / Glaucoma
☐Y ☐N Mental Health Problems	☐Y ☐N Diabetes? Last Test:______ Reading:_______ ☐ Family History
☐Y ☐N Kidney Problems / Dialysis	☐Y ☐N Prosthetic Joint(s) Where: ___________________
☐Y ☐N Weight ☐ Loss or ☐ Gain	☐Y ☐N Hepatitis / Jaundice / Liver Disease or Problems
☐Y ☐N Oral or Facial Piercing	☐Y ☐N TMJ /Pain or Clicking of Jaw(s) When Eating
☐Y ☐N Removable Denture or Plate	☐Y ☐N Problems w/ General Anesthesia or family
☐Y ☐N Stomach Ulcers	☐Y ☐N Urinate more than 6 Times Per Day
☐Y ☐N Arthritis	☐Y ☐N Cancer/Tumor (or Growth) / Chemo When:_____________
☐Y ☐N Gall Bladder Problems	☐Y ☐N Frequent or Severe Headaches
☐Y ☐N Malignant Hyperthermia	☐Y ☐N Low Blood Sugar

☐Y ☐N Do you have a disease, condition, or problem not listed previously that you feel we should know about?

Describe:____

SIGNATURE: Page 1 of 2

I understand the information I provide on this form is essential to determine my dental needs & the provision of treatment. I understand that if any changes occur in my health, I will report it as soon as possible. I have read & understand the questions and answered them truthfully and to the best of my ability. I have had the opportunity to discuss my health history with Dr. Alman.

____ ____________
Signature (☐ Patient ☐ Parent ☐ Legal Guardian) Date:

____ ____________
Dr. Ralph Alman, Jr. Date:

RALPH W ALMAN, JR, DDS, PA
Dental Implants ✦ Oral Maxillofacial Surgery

Date: ___________

HEALTH HISTORY FORM – page 2 of 2

WOMEN ONLY:

☐Y ☐N Are you or is it possible you are pregnant? If Yes: What Trimester Are You In? __ ☐Y ☐N Are you nursing?
☐Y ☐N Do you take birth control or hormone replacement therapy(HRT)?

ALLERGIES & REACTIONS:

☐Y ☐N Are you allergic to or have had an adverse reaction to the following?

Please note the reaction – Rash, Hives, Itching, Swelling, Wheezing, or any other symptom

		Reaction:			Reaction:
Penicillin	☐Y ☐N	________________	Aspirin, Acetaminophen, Ibuprofen	☐Y ☐N	________________
Other Antibiotics (Sulfa)	☐Y ☐N	________________	Codeine, Demerol, Other Narcotics	☐Y ☐N	________________
Local Anesthetics	☐Y ☐N	________________	Barbiturates, Sedatives/Sleeping Pills	☐Y ☐N	________________
Aspirin	☐Y ☐N	________________	Egg Yolks or Soy Beans	☐Y ☐N	________________
Latex or Rubber Dams	☐Y ☐N	________________	Adhesive Tapes or Bandages	☐Y ☐N	________________
Metals	☐Y ☐N	________________	OTHER: ______________________		________________

MEDICATIONS:

☐ None of the below apply.

Current & Last 12 Months	Medication & Dosage:	Current & Last 12 Months	Medication & Dosage:
☐Y ☐N ☐12	Blood Thinners/Anticoagulants: ________________________	☐Y ☐N ☐12	Antibiotics: ____________________________________
☐Y ☐N ☐12	Aspirin (including baby)	☐Y ☐N ☐12	Steroids such as Prednisone (cortisone): ____________________________________
☐Y ☐N ☐12	Allergy Medication(s): ________________________	☐Y ☐N ☐12	Medication(s) for Osteoporosis (Bone Density) ____________________________ Last Taken: __________
☐Y ☐N ☐12	Tranquilizer(s): ________________________	☐Y ☐N ☐12	High Blood Pressure Medication: ____________________________________
☐Y ☐N ☐12	Insulin/Drug(s) for Blood Sugar: ________________________	☐Y ☐N ☐12	Digitalis or Drugs for Heart Conditions: ____________________________________
☐Y ☐N ☐12	Nitroglycerin	☐Y ☐N ☐12	Natural/Herbal Remedies: ____________________________________
☐Y ☐N ☐12	Other: PLEASE DETAIL BELOW	☐Y ☐N ☐12	Nonprescription Drugs/Supplements (i.e. Diet Supplements): ____________________________________

☐ See Attached List (If you have a have a list of medications we are pleased to make a copy to attach):

Medication(s):	What Med is For:	Dose & Frequency:	Medical Doctor Prescribing:
____________________	______________	________________	____
____________________	______________	________________	____
____________________	______________	________________	____
____________________	______________	________________	____
____________________	______________	________________	____

Other: Activities

☐Y ☐N Do you have plans to ☐ travel and/or ☐ fly soon? Details: ____
☐Y ☐N ☐ Athlete ☐ Swimmer
☐Y ☐N ☐ Play a Wind Instrument ☐ Singer

SIGNATURE: Page 2 of 2

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____ ____________
Signature (☐ Patient ☐ Parent ☐ Legal Guardian) Date:

____ ____________
Dr. Ralph Alman, Jr. Date:

RALPH W ALMAN, JR, DDS, PA

Dental Implants ▪ Oral Maxillofacial Surgery

Diplomate, American Board of Oral & Maxillofacial Surgery

Fellow, American Dental Society of Anesthesiology & Diplomate, National Dental Board of Anesthesiology

COVID-19 PANDEMIC EMERGENCY ORAL SURGERY TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other oral surgery and dental patients, the characteristics of the virus, and the characteristics of dental and oral surgery procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental and oral surgery procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental and oral surgery treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non- essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental and oral surgery emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental and oral surgery care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental or oral surgery office or with dental or oral surgery treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

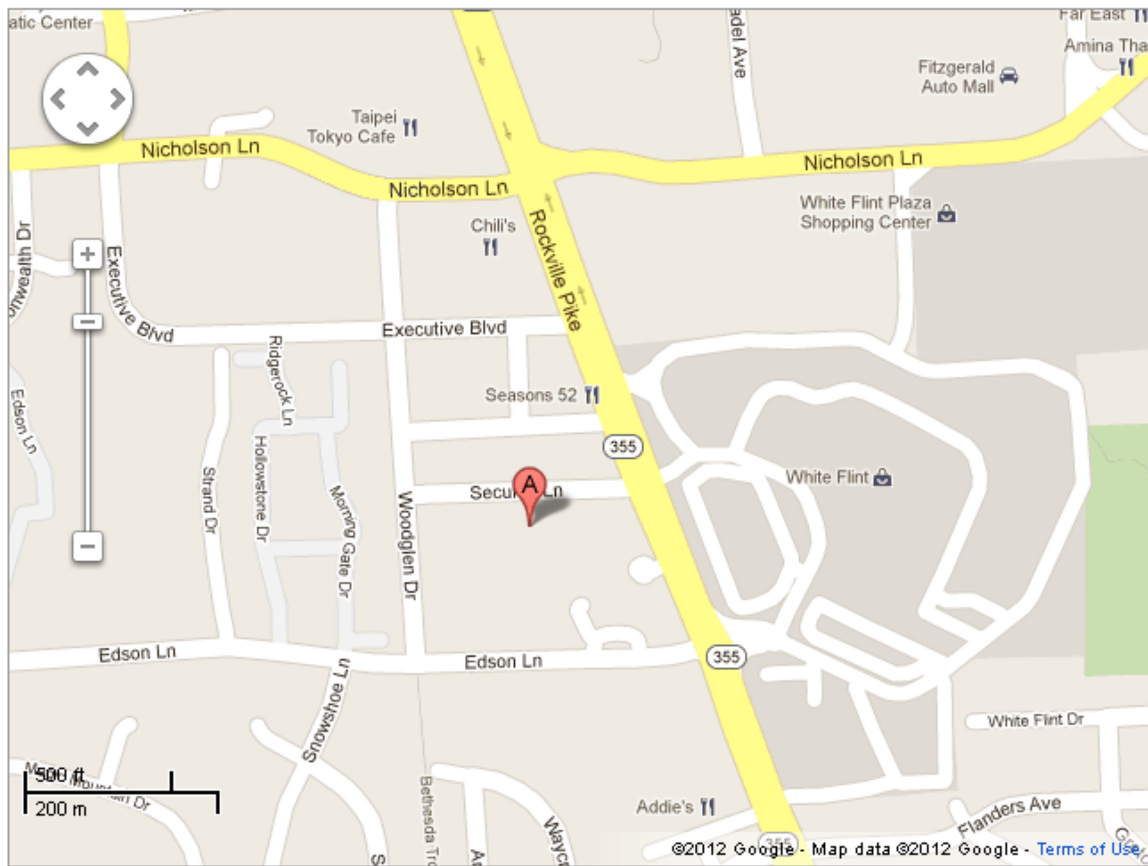
______________________________ __________________________

Signature Date

____

Witness

RALPH W. ALMAN JR. D.D.S., PA



Directions

The office is located directly across the street from White Flint Mall on Security Lane, in the One Central Plaza Building. The entrance to building is located on Security Lane. We are located on the 10th floor, suite 1011.

There is metered parking on Security Lane, as well as parking in the building (we do not provide validation).

11300 ROCKVILLE PIKE SUITE #1011
ROCKVILLE, MARYLAND 20852
OFFICE 301.881.8803 FAX 301.881.4250