Bethesda Medical Building
8218 Wisconsin Avenue, Suite 415
Bethesda, MD 20814

Dear Patient,

Welcome to Malcomson Dentistry! We are committed to provide you with individualized dental care, potentially reducing extensive, future dental treatments. Our patients appreciate Dr. Malcomson's conservative, yet professional approach to emergent and non-emergent dental care. Malcomson Dentistry patients can expect...

- An expert level of professional skill and ability.
- Dedication to your oral health.
- ***The Right Treatment at the Right Time!***

We do ask that when questions arise, communication is key. Dr. Malcomson or the Practice Manager are available to answers any and all questions to the best of their ability. Lack of communication and a misunderstanding can be an unnecessary obstacle in patient / dentist relationship.

Malcomson Dentistry is a 'fee for service' dental practice, and a 'non-network dental provider' meaning, payment for ALL dental services are to be paid in full, at the completion of your appointment. When a patient has dental insurance, they will be offered the appropriate forms to submit, in order to receive direct reimbursement from your dental insurance provider.

Please contact the office during our business hours, which are: Monday through Thursday 7:30AM - 3:30PM and Friday 7AM - 12:00PM.

Complete the following registration forms, and bring or email in advance prior to your first appointment:

- ✓ **Patient Registration**
- ✓ **Medical History**
- ✓ **Radiograph & Records Release Request**

See you soon!

[signature]

E. Denise Malcomson, D.D.S.

Public parking is available in the Woodmont - Rugby garage located at 8216 Woodmont Avenue. To pay, download the **MobileNow!** app on your smartphone. For patients who reside or who work within Bethesda city limits, the **Bethesda Circulator** runs every 15 minutes with a bus stop located on Woodmont Avenue, near the rear entrance of the Bethesda Medical Building. If taking the Metro, our office is located within walking distance from *Medical Center* (red line.)

Patient Registration

Name: ____ **Date of Birth:** _____/_____/_____
Last First M.I.

Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ______________

Home: (_____)______________ **Cell:** (_____)______________ **Work:** (_____)______________

Email: ______________@______________.com **Preferred method(s): Email / Text / Phone**

Occupation: ______________________ Company: ______________________

Address: ____

In case of Emergency, whom should we contact:

Name / Relationship: ______________________ Phone Number: (____)____________

Preferred Pharmacy, Location & Phone Number: ______________________ (____)____________

Malcomson Dentistry accepts the following forms of payment: MasterCard, VISA, DISCOVER, Cash and Check

Who is financially responsible for this account? ______________________ Relationship: ______________

I understand and agree that (regardless of insurance status) I am ultimately responsible for the fees charged to my account for all professional services rendered at Malcomson Dentistry. I have reviewed, completed and signed ALL of the required forms: Patient Registration, Medical History, Acknowledgment of Receipt of Notice of Health Portability and Accountability Act and Privacy Practices prior to my dental appointment. I hereby certify the above information on any forms to be true and correct to the best of my knowledge and will notify Malcomson Dentistry staff when changes occur. I fully understand that a I may be charged a fee for a missed appointment, without at least 24 hours notice.

Patient or Guardian's Signature: ______________________________ **Date:** _____/_____/_____

Patient Medical History

Patient's Name: ______________________________ **Approx. Date of LAST Physical:** ____/____/____

Primary Care Physician: **Dr.** ______________________________ Phone Number: (_____)__________________

Pharmacy & Location: ______________________________ Phone Number: (_____)__________________

		Y	N
1.	Are you currently under medical care? *If yes, please specify:* ______________________	Y	N
2.	List **ALL** medications (prescription, non-prescription, homeopathic/herbal supplements *and* recreational drugs) ______________________________	Y	N
3.	In the past 5 years, have you had surgery (joint, cosmetic, etc.), a serious illness or significant weight loss? *If yes, please specify:* ______________________	Y	N
4.	Have you ever taken *(circle)*: Fen-Phen / Dexfenfluramine / Bisphosphonates?	Y	N
5.	Do you currently *(circle)*: chew tobacco / smoke / vape / e-cigarettes?	Y	N
6.	**Women ONLY (circle):** Are you pregnant or think you may be pregnant / breast feeding?	Y	N
	Are you using any form of oral or implanted contraception?	Y	N

Check ALL applicable medical conditions:

- ○ Allergies / Hay Fever
- ○ Sinus Problems
- ○ Asthma
- ○ **Respiratory Disease / COPD**
- ○ **Pneumocystitis**
- ○ Emphysema
- ○ Tuberculosis
- ○ Acid Reflux / Ulcer
- ○ Arthritis / Rheumatism
- ○ Back Problems
- ○ **Osteoporosis** medication ____________________
- ○ **Cancer Treatment: Chemo / Radiation Therapy**
- ○ **HIGH** Blood Pressure
- ○ **LOW** Blood Pressure
- ○ Fainting Spells
- ○ Rheumatic Fever
- ○ Anemia
- ○ Abnormal Bleeding
- ○ Hemophilia
- ○ Blood Transfusion
- ○ Artificial Bones
- ○ **Artificial Joint Replacement**
- ○ **Other Implant:**____________
- ○ Angina Pectoris
- ○ Congenital Heart Defect
- ○ Heart Murmur
- ○ Heart Attack
- ○ **Cardiac Incident / Pacemaker /** or **Atrial Fibrillation**
- ○ **Artificial Heart Valve**
- ○ Heart Valve Replacement
- ○ Mitral Valve Prolapse
- ○ Stroke
- ○ Circulatory Problems
- ○ Edema / Swelling of Ankles/Feet
- ○ Colitis / IBS
- ○ Epilepsy
- ○ Seizures
- ○ Contact Lenses
- ○ Glaucoma
- ○ Headaches / Migraines
- ○ Diabetes
- ○ Sickle Cell Disease
- Kidney / Bladder Disease
- ○ Liver Disease / Jaundice
- ○ Shingles
- ○ Cortizone / Steroid Therapy
- ○ **Thyroid Problems**
- ○ Psychiatric Care
- ○ Alcohol Dependency
- ○ **Drug / Substance / Chemical Dependency**
- ○ Hepatitis: _____
- ○ STI(s):_ ____________
- ○ **Immune System Disorder: AIDS / HIV / ARC**

LIST / CIRCLE allergies:
- Antibiotics – Aspirin – Codeine - Dental Anesthetics – Erythromycin – Jewelry – Latex - Local Anesthesia – Metals – Penicillin - Sulfa drugs - - Tetracycline

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I attest to the best of my knowledge, that I have honestly answered all medical questions, checked and listed all allergies. I understand that providing incorrect or misinformation can be dangerous to my health and Dr. E. Denise Malcomson and Malcomson Dentistry staff will not be responsible for errors and omissions that I make on this form.

Patient or Guardian's Signature: ______________________________ **Date:** ____/____/____

Radiograph and Records Release Request

To:____ (Previous Dentist)

Address: ______________________________________ State: ________ Zip: ___________

Email: _____________@__________.com Phone: (____)___________ FAX: (____)___________

I authorize the release of my dental radiographs, along with a copy of my dental records to:

Malcomson Dentistry
E. Denise Malcomson, D.D.S.
8218 Wisconsin Avenue, Suite 415
Bethesda, MD 20814
Office: (301) 656-1588
Email: MalcomsonDentistry@gmail.com
www.MalcomsonDentistry.com

Last set of Bitewings (BWX) Date: ____________

Last Full Mouth Series (FMX) Date: ____________

Panoramic radiograph (PANO) Date: ____________

Periapical xrays (PAs) Date: ____________

______________________________ ______________________________ ____________

PRINT Patient Name | Patient or Guardian's Signature | Date

- Please cancel any scheduled appointments.

~CONFIDENTIAL~