WELCOME TO OUR OFFICE

Name____ Birthdate____________________________

Nickname________________________ Social Security Number_____________________________

☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address____

City, State and Zip Code____Home Phone______________

E-Mail Address ____ Work Phone________________

Employer_________________________Occupation___________________Cell Phone________________

Employment Address____

Who May We Thank for Referring You? ____

Someone not living with you to notify in case of emergency________________________Phone_____________

Responsible Party (if other than self)

Name____Birthdate___________________________

Relationship to Patient__________________________Social Security #_____________________________

Address____

City, State and Zip Code____Home Phone______________

Employer____________________________Occupation_________________Work Phone______________

Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured__________________________	Name of Insured________________________________
Relationship to Patient_____________________	Relationship to Patient___________________________
Insured's Birthdate________________________	Insured's Birthdate_______________________________
Soc. Sec. #_______________________________	Soc. Sec. #_____________________________________
Insurance Company_______________________	Insurance Company______________________________
Membership #____________________________	Membership #___________________________________
Group #_________________________________	Group #____
Effective date ____________________________	Effective Date___________________________________

Authorization and Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning patient's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning patient's health care, advice and treatment to another dentist.

I authorize and request the insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I authorize the dentist or staff to take photographs of my care and treatment, which may be used for the advancement of dentistry and educational viewing by other dentists and staff.

I understand that the dental insurance carrier may pay less than the actual fees for service. I agree to be responsible for all services rendered on the patient's behalf.

I attest to the accuracy of the information on this page.

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Signature of Patient or Parent/Legal Guardian Relationship to Patient Date

Name:________________________Cell/Home phone:__________________ email:_____________________________

Address: ____

Physician:______________________________ Office Phone: ____________________ Date of Last Exam:__________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medication ?	☐	☐

Please list:______________________________________

____

	Yes	No
4. Do you use tobacco?	☐	☐
5. Do you use cocaine or other drugs?	☐	☐
6. Women Only:		
a) Are you pregnant or think you may be pregnant? Due date: _______________	☐	☐
b) Are you nursing?	☐	☐
c) Are you using birth control pills	☐	☐

7. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetic	☐	☐
Penicillin or other antibiotic	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Tylenol	☐	☐
Aspirin	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Others	☐	☐

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8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Thyroid Problem	☐	☐	Sexually transmitted Disease	☐	☐
Heart Attack	☐	☐	Heart Disease	☐	☐	Ulcers	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Chest Pains	☐	☐
Swollen Ankles	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Fainting/Seizures	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Asthma	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Recent Weight Loss	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV	☐	☐						

Any other medical conditions:

Patient Dental History

Date of Last Exam: ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold?	☐	☐
3. Are your teeth sensitive to sweet or sour foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you had ever experienced any of the following problems to your jaw?		
a) Clicking	☐	☐
b) Pain (joint, ear, side of face)	☐	☐
c) Difficulty in opening and closing	☐	☐
d) Difficulty in chewing	☐	☐

Date of Last X-ray: _________________

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Are you happy with the appearance of your smile?	☐	☐
15. Would you like to have a complimentary imaging of your smile?	☐	☐

Signature of patient or parent if minor: ____ **Date**: ________________________

Medical History Update:

Date	Comments	Patient's Signature	Initials

HIPPA Privacy Policy

NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of this day, this month and this year we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Germantown Dental & Cosmetic Center
19512 Amaranth Dr. Suite A
Germantown, MD 20874
301-540-0500

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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.

____
Print Name of Patient or Parent/Legal Guardian

____ ____
Signature of Patient or Parent/Legal Guardian Date

Germantown Dental & Cosmetic Center
19512 Amaranth Drive, Suite A, Germantown, MD 20874, P: 301-540-0500, F: 301-540-4899
www.germantowndentalgroup.com

Office and Financial Policies

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment co-pay in full on the day of each visit to our office unless prior arrangements have been made.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Deposit is required to schedule any extensive dental appointment. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 48 hours advance notice for rescheduling your appointment. Your account will be charged a **broken appointment fee of $75.00** for repeatedly missed appointments without proper notification.
We will do our best to give you a general estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close *estimate* of your next visit's total bill. Please bring cash, credit cards or check at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.
Outstanding balances must be cleared before next appointment for any account member within 30 days of treatment or whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $3.00 monthly billing fee per treatment.
Delinquent Balances over 90 days old will be referred to the collection agency automatically. All referred accounts are marked **Inactive**. In order to have your account **Reactivated**, and continue to receive dental treatment in our office, the delinquent balance plus 50% of the delinquent balance referred to the collection agency will be charged to your account. Only after this total account balance has been paid in full can appointments be made and your account and patient status be reactivated.
A returned check fee of $45.00 will be added to your account for any returned check. A check payment will not be accepted for any account that has returned check. In not paid within 7 days, local court will take over the case.

Office policy for patients with dental insurance:
You need to bring your insurance card at the time of the appointment. Dental office should be notified immediately of any changes into your dental plan.
You need to be aware that:

- **We will always do our best** to help you to maximize your benefits
- Although **we file claims for you as a courtesy**, your dental insurance policy is a contract between you, your employer and your insurance company.
- **Not all services are covered benefits**. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy.
- **Your claim will be filed immediately** and benefits are expected are to be paid within 30 days. The filling of an insurance claim does not relieve you of timely payment on your account. If your insurance carrier does not clear the claim in 45 days, the unpaid portions will automatically become self-pay and a statement will be issued to you for the unpaid portion.
- **You are responsible** for any amount your insurance company chooses not to pay, for whichever reason. Any amounts expected to be paid by your insurance company, but not cleared within 45 days become your responsibility and if not paid in timely fashion, will begin to accumulate interest at the rate of 1.5% per month with the billing charges of $5.00 per month. Please feel free to contact your insurance company regarding unpaid balance. We will gladly provide you with a letter, which would include all pertinent information to reprocess the claim that you may sign and mail.
- *In the event that an employee suffers an exposure during your dental treatment, you consent to have blood drawn to provide pertinent medical information for the employee involved. All medical information is kept confidential and will only be provided by the physician to the involved employee as well as yourself.*
- *We are required by law to maintain all records for our patients and therefore cannot release originals of any x-rays or chart materials. Duplication charges are applicable if you would like copies of your x-rays or chart materials. All fees must be paid prior to the release of materials.*

I understand and accept the financial and dental insurance policies listed above and have had any and all questions answered to my satisfaction. ***I Agree*** *to pay for all treatment in a timely fashion as described so as to avoid any additional fees. I realize that I am responsible to pay for any deductibles amounts, my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fee whether or not paid by said insurance company and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier. This order remains in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.*

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Patient (Or Parent of minor) Date

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Staff Member: Date

Payment Options: Please chose one option below:

1) I would like to pay my estimated portion by cash/ check/ credit cards at the time of service. I authorize **Germantown Dental Group & Cosmetic Center** to keep my credit card on file and charge the card for any remaining balance after insurance payment to avoid any billing charges.

Credit/Debit card #: ____**Exp:** ______________**Card Type:** ______________ **CVV:** ___________

There will be 5% discount for patients who will pay upfront in full!

2) I would like to apply for an extended payment plan. We offer up to 12 months interest free payment option. Credit approval is based on your credit score.