SMITH & CO. DENTAL PRACTITIONERS

2110 North Fountain Green Road, Bel Air, MD 21015|(410)638-0920

PATIENT REGISTRATION

PATIENT DETAILS

First Name: _____ Last Name: _____ Middle Name:_____

Preferred Name:_____ Date Of Birth: _____

Address: _____

City: _____ Zip:_____ State:_____

Gender: _____ Marital Status: _____ Employer: _____

CONTACT INFORMATION

Email: _____

Home Phone Number: _____ Cell Phone Number:_____

Work Phone Number: _____ Work Extension: _____

RESPONSIBLE PARTY'S INFORMATION

Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____

DENTAL INSURANCE (PRIMARY SUBSCRIBER DETAILS)

Name of Primary Subscriber: _____ Relation to Patient: _____

Subscriber's SSN: _____ Dental Insurance Company: _____

Subscriber's Employer: _____ Member/Subscriber ID: _____

Subscriber's D.O.B.: _____ Group Number: _____

Dental Insurance Company Address: _____

_____ _____

PATIENT SIGNATURE **DATE**

MEDICAL HISTORY

ALLERGIES

Allergy-Aspirin	Y N	Allergy-Erythro	Y N
Allergy-Latex	Y N	Allergy-Sulfa	Y N
Allergy-Codeine	Y N	Allergy-Hay Fever	Y N
Allergy-Penicillin	Y N	Allergy-Other: _____	

MEDICAL CONDITIONS

Anemia	Y N	Arthritis	Y N	Asthma	Y N
Artificial Joints	Y N	Blood Disease	Y N	Cancer	Y N
Diabetes	Y N	Dizziness	Y N	Epilepsy	Y N
Excessive Bleeding	Y N	Fainting	Y N	Head Injuries	Y N
Heart Disease	Y N	Heart Murmur	Y N	Hepatitis	Y N
High Blood Pressure	Y N	HIV/AIDS	Y N	Jaundice	Y N
Kidney Disease	Y N	Liver Disease	Y N	Mental Disorders	Y N
Nervous Disorders	Y N	Pacemaker	Y N	Pregnancy	Y N
Radiation Treatment	Y N	Respiratory Problems	Y N	Rheumatic Fever	Y N
Rheumatism	Y N	Sinus Problems	Y N	Stomach Problems	Y N
Stroke	Y N	Tuberculosis	Y N	Tumors	Y N
Venereal Disease	Y N				

If Other: _____

MEDICATIONS

Are you currently taking any of the following medications?

Pre-Med-Amoxicillin	Y N	Aspirin	Y N	Penicillin	Y N
Clindamycin	Y N	Codeine	Y N	Pre-Med-Other:	Y N

Please list all current medications here or provide the front desk with a complete list to be added to your chart:

_____

_____

_____

_____

_____

_____ _____

PATIENT SIGNATURE **DATE**

FINANCIAL POLICY

Please read carefully and sign to acknowledge understanding and agreement.

Thank you for choosing Smith & Co. Dental Practitioners as your dental care provider.
We are committed to providing you with the best dental care available.

PAYMENT OPTIONS

Cash, Check, Visa, Mastercard, Discover, American Express
Third-party financing options: CareCredit, Compassionate Finance plans. Please see us for further information.

INSURANCES & COLLECTING PAYMENTS

Copays and deductibles will be **collected on the day of treatment.**
Any **estimates** given by either our office or your insurance company **are not a guarantee of their payment.**

Patients are responsible for any remaining amount not paid by insurance.
For services that are not covered by your insurance, the full fee will be collected at the date of treatment.

We will do our best to answer any questions we can about your insurance and, when possible, we will assist in resolving complications with your insurance company. Please be aware, we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer, and your insurance carrier.
Again, please note that in the event that your insurance company has not paid (on your behalf), you will be responsible to pay for your account.

PATIENTS WITHOUT INSURANCE

Patients without insurance coverage will be responsible for all payments on the day of treatment.
We offer an **in-office membership plan**, which may reduce your costs. Ask a staff member about details.

CANCELLATIONS/NO-SHOWS/RESCHEDULING

Our office requires a minimum of 24 hours' notice to cancel or reschedule your appointment for any reason. Failure to provide adequate notice will result in a $50.00 fee for hygiene appointments and $100.00 fee for doctor appointments–*per patient appointment*.

COLLECTIONS

A charge will be added to your account for any returned checks. If your account becomes assigned to a collection agency, **you will pay a 25% collection fee, interest at 18%, court costs, and attorney fees**.

I hereby authorize payment to Smith & Co. Dental Practitioners by the group insurance.

_____ _____

PATIENT SIGNATURE **DATE**

GENERAL CONSENT

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (e.g., gum treatment and surgery), oral surgery (extractions), endodontics (root canals), restorative dentistry (crowns and fillings), fixed and removable prosthodontics (bridges, and dentures), implant dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography. Some procedures may be performed by dental professionals other than my general dentist, including a dental assistant or hygienist, who have been trained to perform certain tasks, and as permitted by Maryland law.

2. I will provide a thorough and complete medical history, supply a complete list of my medications with doses specified, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. **No guarantees can be made about treatment outcomes, restoration longevity, or prognoses.** I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. Payment is due on the date of service, and I am responsible for the full amount owed, regardless of any insurance policy I may or may not have. The practice will help in filling in any forms needed for insurance reimbursement and those payments will be given to the patient. There is no guarantee that an insurance company will cover work that may be performed.

5. My treatment plan may change at any time, and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am responsible for clarifying any aspects of my dental treatment that I am confused or uncertain about.

7. Most dental procedures require the use of dental anesthetic or numbing to complete the procedure. I understand that there are risks involved in using anesthetic, which includes permanent or temporary loss of feeling and/or muscle control from nerve damage, pain from the injection site, including muscle tightness or even muscle damage that may or may not go back to the normal, allergic reaction, and other side effects.

_____ _____

PATIENT SIGNATURE **DATE**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CONTENT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider involved in your treatment.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing *at any time*. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you provide written authorization, we cannot use or disclose your health information for any reason except those described here.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your

request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I, hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

****You may refuse to sign this acknowledgment.**

Disclosure:

We may discuss all my health/account information to:

_____ _____

Name **Relation to Patient**

_____ _____

PATIENT SIGNATURE **DATE**