PATIENT INFORMATION FORM

Date _____

Patient Information:

Patient Name_____
Last Name First Name Middle Initial

Address _____
Address 1 _____
City _____
State _____ Zip _____
Sex _____ Age _____
Date of Birth _____
___ Married __Widowed __Single __Minor
___ Separate __Divorced __Partnered for __years

Contact Information:

Home _____ Mobile_____
Work _____ Ext,_____
E-mail _____
Best time and place to reach you _____

Patient Employer/ School _____
Occupation _____
Employer/ School Address _____
_____
Employer/ School Phone _____
Spouse's Name _____
Date of Birth _____SS# _____
Spouse's Employer _____

Phone Numbers

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Reason for Today's visit _____
Former Dentist _____City/State_____
Date of last Dental Visit _____Date of Last Dental X-rays _____

Place a mark if you have, or have you had, any of the following:

Bad breath ___	Bleeding gums ___	Blisters on lips or mouth ___	Burning sensation on Tongue ___
Chew on one side of mouth ___	Clicking or popping Jaw ___	Dry mouth ___	Fingernail biting ___
Food collection between Teeth ___	Grinding teeth ___	Gums swollen or tender ___	Jaw pain or tiredness ___
Lip or cheek biting ___	Loose teeth ___	Broken fillings ___	Mouth breathing ___
Mouth pain brushing ___	Orthodontic treatment ___	Pain around ear ___	Periodontal treatment ___
Sensitivity to cold ___	Sensitivity to heat ___	Sensitivity to sweets ___	Sensitivity when biting ___
Sores or growths in your Mouth ___			

How often do you floss? _____How often do you brush?_____

FAMILY SMILE DENTAL CENTER 20500 SENECA MEADOWS PARKWAY SUITE 2200 / GERMANTOWN, MD 20876 / (301)515-9600 familysmiledentalcenter.com

Date _____

HEALTH HISTORY

Patient name: _____ Date of Birth _____

Physician's name: _____

Have you ever been hospitalized or had a major operation? YES NO If yes, explain: _____
Have you ever had a serious head or neck injury? YES NO _____
Do you take, or have taken, Fen-phen or Redux? YES NO _____
Do you use tobacco? YES NO _____
Do you snore? YES NO _____

Place a mark on "yes " of "no" to indicate if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			**Cortisone Treatments**			**Hemophilia**			**Renal Dialysis**		
Alzheimer's Disease			**Diabetes**			**Hepatitis A**			**Rheumatic Fever**		
Anaphylaxis			**Drug Addiction**			**Hepatitis B or C**			**Rheumatism**		
Anemia			**Easily Winded**			**Herpes**			**Scarlet Fever**		
Angina			**Emphysema**			**High Blood Pressure**			**Shingles**		
Arthritis/Gout			**Epilepsy or Seizures**			**Hives or Rash**			**Sickle Cell Disease**		
Artificial Heart Valve			**Excessive Bleeding**			**Hypoglycemia**			**Sinus Trouble**		
Artificial Joint			**Excessive Thirst**			**Irregular Heartbeat**			**Spina Bifida**		
Asthma			**Fainting Spells/Dizziness**			**Kidney Problems**			**Stomach/Intestinal Disease**		
Blood Disease			**Frequent Cough**			**Leukemia**			**Stroke**		
Blood Transfusion			**Frequent Diarrhea**			**Liver Disease**			**Swelling of Limbs**		
Breathing Problem			**Frequent Headaches**			**Low Blood Pressure**			**Thyroid Disease**		
Bruise Easily			**Genital Herpes**			**Lung Disease**			**Tonsillitis**		
Cancer			**Glaucoma**			**Mitral Valve Prolapse**			**Tuberculosis**		
Chemotherapy			**Hay Fever**			**Pain in Jaw Joints**			**Tumors of Growths**		
Chest Pains			**Heart Attack/Failure**			**Parathyroid Disease**			**Ulcers**		
Cold Sores/Fever Blisters			**Heart Murmur**			**Psychiatric Care**			**Venereal Disease**		
Congenital Heart Disorder			**Heart Pace Maker**			**Radiation Treatments**			**Yellow Jaundice**		
Convulsions			**Heart Trouble/Disease**			**Recent Weight Loss**			**Women: Pregnant**		

MEDICATIONS	**ALLERGIES**
List all your medications: _____ _____ _____ _____ _____ _____ _____	Aspirin ___ Codeine ___ Iodine ___ Latex ___ Local Anesthetic ___ Penicillin ___ Sulfa ___ Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____

MEDICAL HISTORY UPDATES (to be filled in future appointments) **Date** _____

Patient name: _____ Date of Birth _____

Has there been any change in your health and/or medical history since your last dental appointment? ___Yes ___No
If yes, please explain: _____

_____

_____

_____

_____

Are you taking any new medications? Be sure to include any nonprescription medicines you are taking. ___Yes ___ No

If yes, please list all medications:_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____

NAME OF PARENT or GUARDIAN_____

MEDICAL HISTORY UPDATES (to be filled in future appointments) **Date** _____

Patient name: _____ Date of Birth _____

Has there been any change in your health and/or medical history since your last dental appointment? ___Yes ___No
If yes, please explain: _____

_____

_____

_____

_____

Are you taking any new medications? Be sure to include any nonprescription medicines you are taking. ___Yes ___ No

If yes, please list all medications:_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____**DATE**_____

NAME OF PARENT or GUARDIAN _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- You May Refuse to Sign This Acknowledgement

I, _____, have receive a copy of this office's Notice of Privacy Practice.

Please, Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but

Acknowledgment could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgment
- ○ An emergency situation prevented us from obtaining acknowledgment
- ○ Other (please specify)

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 IT 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 about 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. This Notice is in effect now and will remain in effect until we replace it.

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 our Privacy Coordinator by calling (301) 515-9600 or writing to Family Smile Dental Center, Attention: Privacy Coordinator, 20500 Seneca Meadows Parkway, Suite 2200, Germantown, MD 20876.

_____

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 providing treatment to you. We may disclose identification information to a pharmacist.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to contact your health plan to see what coverage you have. We will bill your insurance company, you directly, or another person that may be responsible for payment of your account.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operation include 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. We may call at home or at work and leave a message regarding your appointments, insurance coverage, or payment on your account.

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 an 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 give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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 will an opportunity to object to such uses or disclosure 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, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extant 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, electronic mail 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 practicably 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 above. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address listed above. If you request copies, we will charge you $.50 for each page, and a maximum of $ 20.00 staff time to locate and copy your health information, and postage if you want the copies mailed to you. X-ray copies will be an additional fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.)

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, but not before April 14, 2003. 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.

Restriction: 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.

Complaints: 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 above. 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 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.

FLUORIDE VARNISH CONSENT FORM

As a preventive dental service program, our practice is offering the application of a protective coating called Fluoride Varnish. This application should be applied immediately following a professional cleaning. The American Dental Association recommends application of fluoride varnish for patients who fall into moderate risk to high risk group for dental decay and tooth sensitivity. All patients can benefit from application of fluoride varnish.

You will be considered at risk for dental decay if you had a cavity within the last 3 years or have one of the following risks factors:

- Sensitivity to hot, cold or to certain foods
- Have "dry mouth"
- Have or are being treated for acid reflux
- Consume food high in sugars
- Drink carbonate beverages
- Are under active orthodontic (braces or invisalign) treatment
- Have many multisurface (large) fillings or crowns
- Have gum recession and root exposure

Dental Insurances policies vary on frequency and coverage for fluoride varnish. The fee for application of fluoride without dental insurance coverage is $25.00

By signing below, I am acknowledging that I have read the above service available. At this time I elect to:

___ Have fluoride varnish applied even if my insurance does NOT pay for it.

___ Have fluoride varnish applied only if my insurance plan covers it.

Patient's Name: _____ Date: _____

Signature of patient, parent or legal guardian: _____

FAMILY SMILE DENTAL CENTER
20500 Seneca Meadows Parkway, Suite 2200
Germantown, MD 20876

I hereby agree that Family Smile Dental Center may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **Initial _____**

I understand that my insurance plan may have a maximum amount per year. Whereas this office may help me keeping an estimate of it, it will be my responsibility to contact the insurance company for more accurate and up to date information. **Initial _____**

I understand that I am ultimately financially responsible for all charges whether or not they are covered by the insurance plan. **Initial _____**

Copies of claims and/or insurance payments should be requested directly by me to the insurance company. **Initial _____**

I have read the Notice of Privacy Practice and I am aware that I can request a copy of it at any time. **Initial _____**

I consent to receive mail, electronic mail and/or telephone calls from Family Smile Dental Center. **Initial _____**

Should the treating dentist, refer my account to a collection agency and/or attorney for collection, I agree to pay all collection costs, including but not limited to court cost and attorney fees of 25 percent of my bill. I understand that all delinquent accounts shall bear interest at the rate of 12 percent per annum. **Initial _____**

I understand that there will be a $35.00 processing fee for any dishonored or returned check. **Initial _____**

All appointments must be scheduled in advance. A $60.00 NO SHOW or LATE CANCELLATION fee will apply if I do not cancel my appointment 48 Business hours prior to my appointment.

Initial _____

I, _____ have read and fully understand the above policies; I agree to be personally and fully responsible.

Signature of Patient: _____ Date: _____

Parent or Legal Guardian _____Date: _____