# WELCOME TO KENTLANDS FAMILY DENTISTRY

## PATIENT REGISTRATION

TODAY'S DATE: ___________________

### PATIENT INFORMATION

| FIRST NAME | MI | LAST NAME | NICKNAME OR PREFERRED NAME |
|---|---|---|---|
| EMAIL | | BIRTHDATE | |
| ADDRESS | | OCCUPATION | |
| CITY | STATE | ZIP | |
| MARITAL STATUS<br>☐SINGLE ☐ MARRIED ☐DIVORCED ☐SEPARATED ☐PARTNERSHIP | | GENDER<br>☐MALE ☐FEMALE ☐PREFER NOT TO ANSWER | |
| HOME PHONE | CELL PHONE | WORK PHONE | SOCIAL SECURITY # |

| IF PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING | | | |
|---|---|---|---|
| PARENT/LEGAL GUARDIAN FIRST AND LAST NAME | | RELATIONSHIP TO PATIENT<br>☐PARENT ☐GUARDIAN ☐OTHER | |
| EMAIL | | | |
| ADDRESS<br>☐ SAME AS ABOVE | CITY | STATE | ZIP |
| HOME PHONE | CELL PHONE | WORK PHONE | SOCIAL SECURITY # |

### EMERGENCY CONTACT INFORMATION

| EMERGENCY CONTACT PERSON | PHONE NUMBER | RELATIONSHIP |
|---|---|---|
| | | |

### IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

| PRIMARY CARRIER | | SECONDARY CARRIER | |
|---|---|---|---|
| INSURANCE COMPANY NAME | PHONE | INSURANCE COMPANY NAME | PHONE |
| EMPLOYER NAME | PHONE | EMPLOYER NAME | PHONE |
| PRIMARY INSURED NAME | | PRIMARY INSURED NAME | |
| BIRTHDATE | RELATIONSHIP TO PATIENT | BIRTHDATE | RELATIONSHIP TO PATIENT |
| MEMBER ID | GROUP # | MEMBER ID | GROUP # |
| INSURED SOCIAL SECURITY # | | INSURED SOCIAL SECURITY # | |

### HOW DID YOU HEAR ABOUT US?

☐ OUR WEBSITE ☐ INSURANCE COMPANY ☐ ONLINE SEARCH ☐ SOCIAL MEDIA

☐ CURRENT PATIENT ______________________________________________

NAME OF REFERRING PATIENT

### DENTAL HISTORY

| REASON FOR TODAY'S VISIT | FORMER DENTIST | CITY/STATE |
|---|---|---|
| DATE OF LAST DENTAL VISIT | DATE OF LAST DENTAL XRAYS | |

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| ☐ BAD BREATH | ☐ FINGERNAIL BITING | ☐ MOUTH BREATHING |
| ☐ BLEEDING GUMS | ☐ FOOD COLLECTION BETWEEN TEETH | ☐ MOUTH PAIN, BRUSHING |
| ☐ BLISTERS ON LIPS OR MOUTH | ☐ FOREIGN OBJECTS | ☐ ORTHODONTIC TREATMENT |
| ☐ BURNING SENSATION ON TONGUE | ☐ GRINDING TEETH | ☐ PAIN AROUND EAR |
| ☐ CHEW ON ONE SIDE OF MOUTH | ☐ GUMS SWOLLEN OR TENDER | ☐ PERIODONTAL TREATMENT |
| ☐ CIGARETTE, PIPE OR CIGAR SMOKING | ☐ JAW PAIN OR TIREDNESS | ☐ SENSITVITY TO COLD/HEAT |
| ☐ CLICKING OR POPPING JAW | ☐ LIP OR CHEEK BITING | ☐ SENSITVITY TO WHEN BITING |
| ☐ DRY MOUTH | ☐ LOOSE TEETH OR BROKEN FILLINGS | ☐ SORES OR GROWTHS IN MOUTH |

| HOW OFTEN DO YOU BRUSH? | HOW OFTEN DO YOU FLOSS? |
|---|---|
| ☐ 1X/DAY ☐ 2X/DAY ☐ 3X OR MORE/DAY ☐ I DON'T BRUSH | ☐ DAILY ☐ WEEKLY ☐ I DON'T FLOSS |

## HEALTH HISTORY

| PHYSICIAN'S NAME | DATE OF LAST VISIT | PHYSICIAN PHONE # |
|---|---|---|

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| ☐ AIDS/HIV | ☐ EPILEPSY | ☐ PSYCHIATRIC CARE |
| ☐ ANEMIA | ☐ FAINTING OR DIZZINESS | ☐ RADIATION TREATMENT |
| ☐ ARTHRITIS | ☐ GLAUCOMA | ☐ RESPIRATORY DISEASE |
| ☐ ARTIFICIAL JOINTS | ☐ HEADACHES | ☐ RHEUMATIC FEVER |
| ☐ ASTHMA | ☐ HEART MURMUR | ☐ SCARLET FEVER |
| ☐ BACK PROBLEMS | ☐ HEART PROBLEMS | ☐ SHORTNESS OF BREATH |
| ☐ ABNORMAL BLEEDING | ☐ HEPITITIS TYPE ___________ | ☐SINUS TROUBLE |
| ☐ BLOOD DISEASE | ☐ HERPES | ☐SKIN RASH |
| ☐ CANCER | ☐ HIGH BLOOD PRESSURE | ☐ SPECIAL DIET |
| ☐ CHEMICAL DEPENDENCY | ☐ JAUNDICE | ☐ STROKE |
| ☐ CHEMOTHERAPY | ☐ JAW PAIN | ☐ SWOLLEN FEET/ANKLES |
| ☐ CIRCULATORY PROBLEMS | ☐ KIDNEY DISEASE | ☐ SWOLLEN NECK GLANDS |
| ☐ CONGENTIAL HEART LESIONS | ☐ LIVER DISEASE | ☐ THYROID PROBLEMS |
| ☐ CORTISONE TREATMENTS | ☐ LOW BLOOD PRESSURE | ☐ TONSILITIS |
| ☐ COUGH, PERSISTANT OR BLOODY | ☐ MITRAL VALVE PROLAPSE | ☐ TUBERCULOSIS |
| ☐ DIABETES | ☐ NERVOUS PROBLEMS | ☐ TUMOR/GROWTH NECK OR HEAD |
| ☐ EMPHYSEMA | ☐ PACEMAKER | ☐ ULCER |
| ☐ VENEREAL DISEASE | ☐ UNEXPLAINED WEIGHT LOSS | |

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

**WOMEN:**

ARE YOU PREGNANT? ☐ YES ☐ NO DUE DATE: ___________________

ARE YOU NURSING? ☐ YES ☐ NO

TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRESPONDING DIAGNOSIS

PLEASE LIST ANY ALLERGIES

# FINANCIAL POLICY

Kentlands Family Dentistry's philosophy is to provide each patient with excellent dental care in an assuring and pleasant environment. As a courtesy to you, and to help make your experience as easy as reasonably possible, Kentlands Family Dentistry files insurance claims on your behalf. However, all fees are ultimately your responsibility. **Not all services are covered by all insurance plans and we not know the details of all insurance plans.** While Kentlands Family Dentistry will endeavor to inform you of any charges we are aware of that are not covered by your policy, **it is your responsibility to know what services are covered by your insurance policy**. If there is a dispute with your insurance company, we will help you try to resolve it.

**Due to frequent changes in dental insurance, we require proof of insurance at EACH visit.**

If we are a participating provider for your insurance, all copay and coinsurance amounts are due at the time of service. The parent/guardian accompanying a minor is responsible for payment at the time of service. If you do not have insurance, are not in a plan in which we participate, or are unable to provide proof of insurance coverage, full payment is required at the time of your visit.

We accept cash, check, and credit cards. Returned checks will be subject to a **$35.00** fee, and any outstanding balances older than 30 days will be subject to interest charges of **1.5% per month**. Charges may also be made for broken appointments and appointments not canceled 24 hours advance notice. In the unfortunate event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for the reasonable cost (35% of the past due balance) of a collection agency, attorney, and/or court costs.

***The undersigned hereby waives any defense he/she may have as to the Statute of Limitations barring future attempts to recover debts owed hereunder in the event of default.***

**You will be charged $40 for missing an appointment or for failing to provide at least 24 hours notice for appointment cancellations.** This charge cannot be billed to your insurance company and must be paid in full prior to future appointments. Three missed appointments or late cancellations may result in dismissal from the practice.

By signing below, I indicate that I reviewed the above office and financial policy and agree to its terms. I understand that I may request a copy of this agreement.

Signature:____________________________________ Date:__________________

# Notice of Privacy Practice

**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 in this Notice while it is in effect. This Notice takes effect October 27, 2016 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 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 changes. Before we make a significant change in our privacy practices, we will change this Notice available upon request. You may request a copy of our Notice at anytime. 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.

**USING 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.

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 anytime. 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 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 persons 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 extent necessary to avert a serious threat to your health or safety of the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certaincircumstances. 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 officialhaving 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 asvoicemail messages, postcards, or letters).

**PATIENT RIGHTS**

Access: You may 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 at the end of this Notice. 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 at the end of this Notice. If you request copies, we charge you $ 5.00 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you wantthe copies mailed to you. 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. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed to 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, 2OO3. 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 Communications: You have the right to request that we may 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 request under certain circumstances.

Electronic Notice: If you receive this Notice on our website 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 decision we made about accessto your health information or in response to a request you made to amend or restrict the use 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. 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.
Contact Officer: Wei Li, DMD Telephone: 301-947-5300 ; Fax: 301-947-9720
Address: 11908 Darnestown Rd, Suite E, North Potomac, MD 20878

I have read and fully understand the Notice of Privacy Practices.

Signature: ____________________________________________ Date:_______________

# PATIENT HIPAA COMMUNICATION FORM

*DISCLOSURE TO SELF AND OTHERS*

Patient Name: ____________________________ Patient DOB: _______________

**FAMILY AND FRIENDS:** It is the office policy of KENTLANDS FAMILY DENTISTRYnot to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members,friends, or caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

________________________________________ __________________ ______________________
NAME RELATIONSHIP PHONE

________________________________________ __________________ ______________________
NAME RELATIONSHIP PHONE

________________________________________ __________________ ______________________
NAME RELATIONSHIP PHONE

**ALTERNATIVE COMMUNICATION**: I wish to be contacted in the following manner. (Check all that apply)

**Home Phone** ___________________________
- ☐ Okay to leave message with details
- ☐ Leave a call back number only

**Cell Phone** ___________________________
- ☐ Okay to leave message with details
- ☐ Leave a call back number only
- ☐ Okay to text with details
- ☐ Text a call back number only

**Work Telephone** ________________________
- ☐ Okay to leave message with details
- ☐ Leave a call back number only

**Written Communication**
- ☐ Okay to mail to home address
- ☐ Okay to send email

_____________________________________________________________________________________________
Patient or Representative Signature Relationship to Patient Date