Patient Information Form

Today's Date:

How did you hear about us?

Name (Last, First, Middle): Preferred Name:

Address (Street, City, Zip code):

E-mail Address:

Home Phone: Cell Phone: Work Phone:

Sex: Marital Status: Social Security No.: Birthdate:

In case of an emergency, who may we contact (name and phone)?

Patient Employed By: Occupation:

Employer's Address:

Dental Insurance Information

Name of Person Responsible for Account:

Relationship to Patient: Social Security No.: Birthdate:

Address (If different from patients):

Home Phone: Cell Phone: Work Phone:

Insured Employer:

Employer Address:

Insurance Company:

Insurance Phone No.: ID No.: Group No.:

Secondary Insurance Information

Name of Person Responsible for Account:

Relationship to Patient: Social Security No.: Birthdate:

Address (If different from patients):

Home Phone: Cell Phone: Work Phone:

Employer and Address:

Insurance Company:

Insurance Address:

Insurance Phone No.: ID No.: Group No.:

Medical History

Are you currently under a physician's care? ☐ If yes, please explain_____

Are you currently taking any medications? ☐ If yes, please list:_____

Have you ever taken any bisphosphonates (ex. Fosamax, Boniva)?_____

Have you ever been hospitalized or had a major operation, explain? _____

Do you use tobacco? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa

Please list any other drugs/materials you are allergic to:_____

Do you have, or have had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Emphysema			Leukemia		
Alzheimer's			Endocarditis			Liver disease		
Anaphylaxis			Epilepsy/seizures			Low blood pressure		
Anemia			Fainting spells			Lung disease		
Angina			Frequent cough			Mitral valve prolapse		
Arthritis/Gout			Glaucoma			Osteoporosis		
Artificial heart valve			Hay fever			Psychiatric care		
Artificial joint			Heart attack/failure			Radiation		
Asthma			Heart murmur			Renal dialysis		
Breathing problems			Heart pacemaker			Rheumatic fever		
Bruise easily			Heart disease			Rheumatism		
Cancer			Hemophilia			Shingles		
Chemotherapy			Hepatitis A, B, C			Sickle cell disease		
Chest pain			Herpes			Stroke		
Cold sores/blisters			High blood pressure			Thyroid disease		
Congenital heart disease			High cholesterol			Tuberculosis		
Convulsions			Hives/rash			Tumors		
Cortisone use			Hypoglycemia			Ulcers		
Diabetes			Irregular heartbeat			Venereal disease		
Drug Addiction			Kidney problems			Acid Reflux		

Please list any other conditions:_____

Women Only:

Pregnant/Trying to be? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Dental History

What is the main purpose for your visit today?_____

Do you currently have any dental pain?_____

Do you require antibiotics before dental treatment?_____

Have you ever had a serious problem associated with dental work? _____

Do you have any pain or discomfort associated with your jaw joint (TMJ)?_____

Are you happy with your smile?_____

Do your gums bleed when brushing or flossing? _____

Does food catch between your teeth?_____

How often do you brush? _____

How often do you floss?_____

Have you ever been told you grind your teeth while sleeping? _____

Are you aware of clenching your teeth during the day?_____

I understand that the information that I have given on these forms is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Patient/Guardian Signature Date

Financial Agreement

Patient acknowledges that payment is due in full at the time of service. If payment plan is needed, payment arrangements must be made prior to time of service. If patient has dental benefits, they understand the responsibility of paying any co-payments, deductibles, and procedures otherwise NOT covered by insurance. All accounts sixty (60) days overdue will be turned over to a professional collection agency. Patient agrees to reimburse North Carroll Dental the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including attorneys' fees that we may incur in such collection efforts. A fee of $35 will be charged for any returned checks.

Signature of acknowledgement: _____ Date: _____

HIPAA Notice of Privacy Practices *Effective Date*: *9/23/2013*

Dr. Lawrence R. Whitney, Jr., DDS, PA
2113 Hanover Pike
Hampstead, MD 21230
410-374-5200

OUR OBLIGATIONS: Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Except for the purposes described below, we will use and disclose Health Information only with your written permission.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to confirm an appointment with us.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information. In the case of a breach of unsecured protected health information, we will notify you as required by law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. We may release Health Information to funeral directors.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so

they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
The following uses and disclosures of your Protected Health Information will be made only with your written authorization: uses and disclosures of Protected Health Information for marketing purposes; and disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:
Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances.
Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.
Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must make your request, in writing.
Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction, you must make your request, in writing. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full.
Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing. ***Right to a Paper Copy of This Notice***. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our web site or ask us for a paper copy.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint you must contact our office. All complaints must be made in writing. You will not be penalized for filing a complaint.

Contact Officer: Sarah Hill
410-374-5200
2113 Hanover Pike
Hampstead, MD 21074

Last Minute Cancellations/Missed Appointments

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $50 charge for not showing up or cancelling less than 48 hours in advance for scheduled appointments. ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

If you have a true emergency and need to reschedule your appointment, please convey this to our staff. Thank you in advance for your understanding.

_____ _____

Patient/Guardian Signature Date

Acknowledgement of HIPAA Privacy Practices

I have read and understood the office's HIPAA Notice of Privacy Practices.

_____

Print Name

_____

Patient/Guardian Signature

_____

Date

I authorize the office to discuss personal treatment and finances with the following individual(s):

_____ _____

Print Name Relationship

_____ _____

Print Name Relationship

_____ _____

Patient/Guardian Signature Date