PATIENT MEDICAL HISTORY

Patients Name:

Address: | **City** | **State:** | **Zip:**

Email: | **Social Security:** | **Birth Date:** | **Marital Status:** S/ M/ D/ W

Home Phone: | **Work Phone:** | **Cell Phone:** | **Date of Last Visit:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only:

Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐☐ Are you taking Birth Control
- ☐☐ Are you Pregnant?
- ☐☐ Are you nursing?

Please answer the following:

Do you Smoke or use tobacco? Yes ☐ No ☐

For office use only:
B/P _____ Heart Rate:

Height:

Weight:

Y N	Conditions	Y N	Conditions	Y N	Conditions		
☐☐	Abnormal Bleeding	☐☐	Drug Abuse	☐☐	Liver Disease	☐☐	Thyroid Problems
☐☐	Alcohol Abuse	☐☐	Emphysema	☐☐	Low Blood Pressure	☐☐	Tuberculosis
☐☐	Allergies	☐☐	Epilepsy/ Seizures	☐☐	Mitral Valve Prolapse	☐☐	Ulcers
☐☐	Anemia	☐☐	Fainting Spells	☐☐	Pace Maker	☐☐	Venereal Disease
☐☐	Angina Pectoris	☐☐	Fever Blisters	☐☐	Pain in Jaw Joints	☐☐	Yellow Jaundice
☐☐	Arthritis	☐☐	Frequent Headaches	☐☐	Pneumocystis	**Allergies**	
☐☐	Artificial Bones	☐☐	Glaucoma	☐☐	Psychiatric Problems	☐☐	Aspirin
☐☐	Artificial Heart Valve	☐☐	HIV + AIDS	☐☐	Radiation Therapy	☐☐	Codeine
☐☐	Aspirin Therapy	☐☐	Heart Attack	☐☐	Rheumatic Fever	☐☐	Dental Anesthetics
☐☐	Asthma	☐☐	Heart Murmur	☐☐	Shingles	☐☐	Erythromycin
☐☐	Blood Transfusion	☐☐	Heart Surgery	☐☐	Sickle Cell Disease	☐☐	Jewelry
☐☐	Cancer - Chemotherapy	☐☐	Hemophilia	☐☐	Sinus Problems	☐☐	Latex
☐☐	Colitis	☐☐	Hepatitis A, B, C	☐☐	Stents	☐☐	Metals
☐☐	Congenital Heart Defect	☐☐	High Blood Pressure	☐☐	Stroke	☐☐	Penicillin
☐☐	Diabetes	☐☐	Kidney Problems	☐☐	Taking Bisphosphonate Drugs	☐☐	Tetracycline
☐☐	Difficulty Breathing	☐☐	Latex Sensitivity			**Other**	
						_____	
						_____	

Medications:

Y N

□ □ Is there any disease, condition or problem that you think this office should know about that is not covered above? If yes, Please describe below…

Notes:

Signature: _____ Date: _____

FINKSBURG DENTAL ASSOCIATES

Name: _____Title:_____
Home Address: _____ Zip Code: _____
Preferred Name: _____ SS#_____-_____-_____ DOB: ____/____/____
Home Phone: _____ Work Phone: _____ Marital: S / M / D / W
Sex: M/ F Cell Phone: _____ Who is responsible for payment of this account_____
Are any other family members patients in our office? Name: _____
Employer: _____
Email:_____

How did you hear about our office? (Ex: friend – Jane Doe)_____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____Relationship to patient: _____
Primary Subscriber Phone #:_____DOB: _____/_____/_____ SS#: _____/_____/_____
Address (if different): _____
Alternate Member ID: _____ Employer: _____
Employer Address: _____
Plan Name: _____ Group # _____
Insurance Co: _____
Insurance Address: _____ Phone #: _____

Secondary Dental Insurance Coverage

Subscriber Name: _____Relationship to patient: _____
Primary Subscriber Phone #:_____DOB: _____/_____/_____ SS#: _____/_____/_____
Address (if different): _____
Alternate Member ID: _____ Employer: _____
Employer Address: _____
Plan Name: _____ Group # _____
Insurance Co: _____
Insurance Address: _____ Phone #: _____

Patient Treatment Consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medication as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and /or requested.
- I agree to be responsible for payment of all services render on my behalf or my dependents.
- **I understand that Finksburg Dental Associates, L.L.C., reserves the right to pursue delinquent accounts via a third party collection agency or attorney. In the event Finksburg Dental Associates, L.L.C., refers my bill for collection, I agree to pay, for collection and/or legal services, an additional thirty percent (30%) of the amount owed.**

Preferred method of payment
☐ Payment in full by cash/check
☐ Payment in full by Visa/ MC
☐ Copayment in full

Patient / Parent or Guardian Signature:

_____

(SEAL) Date: _____ Update: _____

REGISTRATION

FINKSBURG DENTAL ASSOCIATES

Name: _____ Date of Birth: _____ Date: _____

What is the reason for this appointment? _____
Are there any specific dental problems we should be aware of? _____
How long has it been since your last dental visit? _____
What was done at that time? _____
Name of previous dentist? _____
When were your last full mouth x-rays or panorex? _____
How would you describe your dental health? ☐ Excellent ☐ good ☐ fair ☐ poor
How often do you brush on a daily basis? _____ When do you brush? _____
Do you think you have any cavities? _____

Circle Yes or No for the following questions.

Are you unhappy with the appearance of your teeth?	Y OR N
Do your gums bleed easily when you brush or floss?	Y OR N
Do you feel your breath is offensive at times?	Y OR N
Have you experienced any pain or soreness in the muscles in your face or around your ear?	Y OR N
Do you have any areas or food impaction	Y OR N
Do you clench or grind you teeth?	Y OR N
Do you have any swelling or lumps in your mouth?	Y OR N
Have you ever had an unfavorable dental experience?	Y OR N
Have you ever had any complications from an extraction?	Y OR N
Have you ever had gum treatments?	Y OR N
Have you ever had orthodontic treatment?	Y OR N
Have you lost any teeth or had any removed?	Y OR N
Have you ever had prolonged bleeding from an extraction?	Y OR N
Have your missing teeth been replaced?	Y OR N
Are you happy with the replacement(s)?	Y OR N
Do you have any questions or concerns?	Y OR N

How do you feel in general about your smile? _____

I certify that the above information is complete and accurate: _____

Patient/ legal guardian: _____ Date: _____

Dental History

FINKSBURG DENTAL ASSOCIATES

2029 Suffolk Rd
Finksburg, MD 21048

To our private Insurance Patients:
As a courtesy to you, we will be happy to submit for pre-authorization and/or payment to al insurance companies with a completed and signed insurance form. Due to escalating overhead and increasing paper work, **we will initially ask you for only your estimated co-insurance payment. Please understand that this is only an estimate and is based upon the accuracy of the information available to us from your insurance provider. We will also be unable to carry balances unpaid by the insurance carriers longer than 90 days after the initial submission of claims.** After three months, we will require all patients to pay their balances in full and be reimbursed directly from their insurance companies. We reserve the right to pursue all delinquent accounts via a third party collection agency or attorney. Please familiarize yourself with your dental benefits so as to be aware of deductibles, time restraints, yearly maximums and your percentage of financial responsibility.

We would like you to understand fully the ultimate responsibility for payment is yours.

To our HMO Patients:
The patient is responsible for eligibility in their insurance program. Patients not listed on our insurance print out are responsible for payment in full at the time of treatment. **Due to greatly reduced fees, all patient copayments are due at the time of service.** Please familiarize yourself with your individual plan benefits so as to be aware of your financial responsibility for any services we might perform for you.

ALL PATIENTS: AMENDED JANUARY 2012:

We require all patients over the age of 18 to provide us with their **Social Security Number.** Though many insurance companies have unique identification numbers, they are subject to change when your insurance changes. When insurance is involved, we ask you to remember that **we are extending credit to you by collecting only your percentage or co-insurance payment** and billing your insurance company for the balance. In addition, we ask you to remember that your name and date of birth are not always enough to uniquely identify you for records purposes. If you prefer not to make this information available to us we will require cash payment at the time of your visit. All patients are responsible for any co-payment or payment in full at the time of service. Please remember that it is your responsibility to be aware of your insurance benefits including your insurance contract's maximum benefit and your deductible.

Endodontic (root canal) therapy may be necessary subsequent to treatment of teeth having existing deep fillings or decay close to the nerve. This could occur on teeth having no previous symptoms.

All patients under the age of 18 must be accompanied by a parent or legal guardian in order to receive dental treatment.

We reserve the right to charge for broken or missed appointments without 24 hours notice. A fee of $17 per 15 minutes of your appointment time may be assessed for failure to notify the office. A $37 service charge will be assessed for all returned checks.

I have read and fully understand the terms stated above.

Signature: _____ Date: _____

FINKSBURG DENTAL ASSOCIATES

Payment Agreement

I understand that all estimate co-pays, deductibles and fees for procedures not covered by insurance must be paid in full at the time dental services are rendered.

I agree to pay in full today all **estimated** co-pays, deductibles and fees for procedures not covered by insurance by the following method:

_____ Cash

_____ Check

_____ Visa

_____ MasterCard

_____ Discover

_____ Care Credit

_____ _____

Signature of Patient, Parent, Guardian, Responsible Party Date

FINKSBURG DENTAL ASSOCIATES

Finksburg Dental Associates, LLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You May Refuse to Sign This Agreement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Nice of Privacy Practices, But acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify)

_____
_____
_____

FINKSBURG DENTAL ASSOCIATES

Finksburg Dental Associates, LLC

I authorize Finksburg Dental Associates, LLC to discuss personal treatment and finances with the following individual (s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Patient Signature	Date

2029 Suffolk Rd
Finksburg, MD 21048
Phone: (410) 861-8900 * Fax: (410) 861-8445

Dental Associates, LLC

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 takes effect **04/14/03**, 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 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 of 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 an authorization, you may revoke it 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 of 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 you 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 you 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 of 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 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, counter intelligence, 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 of disclose your health information to provide you with appointment reminders (such as voicemail, 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. W 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 will charge you $____ for each page, $____ per hour for staff time to locate and copy your health information, and postage if you want the 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 below 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 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 of 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 of 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 COMPLIANTS

If you want more information about our privacy practices of 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 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 the U.S. Department of Health and Human Services.

Contact Officer: Denise Scheufele
Telephone: (410) 848-5577 Fax: (410) 876-3760
E-mail:
Address: 603 Nursery Road, Westminster, MD 21157

1) LIKE US on facebook for office updates, exclusive promotions & fun prizes!

FACEBOOK.COM/FINKSBURGDENTAL

2) CHECK-IN today!

3) PICK A PRIZE at the front desk!

FINKSBURG DENTAL ASSOCIATES