South River DENTAL CARE

Patient Information

Date:_____

Patient Name: _____ Date of Birth: _____

Email: _____

Home Address:_____

Phone: H:_____ W:_____ C:_____
(Circle Preferred Contact Number)

Marital Status: _____ Social Security #: _____

Driver's License #: _____ State Issued: _____

Employer's Name: _____ Occupation: _____

Person Responsible for the account is ( ) Self ( ) Spouse ( ) Other _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Insurance Information

Name of Insured: _____Subscriber Date of Birth: _____

Relationship to Patient: _____ Insurance Carrier: _____

Subscriber ID #: _____ Group #:_____ _____

Subscribers Employer: _____

Whom may we thank for referring you today?

_____

Medical History

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Please list hospitalizations, major operations or serious illness with the month and year of such:

_____ _____

_____ _____

Please list all medications / drugs you are currently taking:

_____ _____ _____

_____ _____ _____

1) Are you currently under the care of a physician? _____

2) Any change in your health in the past year? _____

3) Have you been hospitalized for any surgical operation or serious illness? Yes No
If yes, explain: _____

4) Have you had had abnormal bleeding? Yes No
If yes, explain: _____

5) Do you bruise easily? _____

6) Have you ever required a blood transfusion? _____

7) Do you use tobacco? _____

8) Do you or have you used control substances? _____

9) Are you wearing contact lenses? _____

WOMEN ONLY

10) Are you pregnant? _____

11) Are you nursing? _____

12) Are you taking birth control? _____

Have you ever had allergic reactions to any of the following?

__Penicillin __Codeine __Anesthetic __Aspirin __Sulfa __Erythromycin __Latex __Jewelry/Metals

__Other - List, _____

Do you have or have you had the following?

	YES	NO		YES	NO
Heart Defect or Heart Murmur	( )	( )	Heart Trouble / Surgery	( )	( )
Chest Pain	( )	( )	Shortness of Breath	( )	( )
Pacemaker	( )	( )	High/Low Blood Pressure	( )	( )
Congenital Heart Problem	( )	( )	Swelling Feet / Hands / Ankles	( )	( )
Hepatitis/Jaundice or Live Disease	( )	( )	Stroke	( )	( )
Sinus Trouble	( )	( )	Asthma or Hay Fever	( )	( )
Lung or Breathing Trouble	( )	( )	Fainting / Dizzy Spells	( )	( )
Diabetes	( )	( )	Diabetes	( )	( )
AIDS / HIV	( )	( )	Thyroid Problems	( )	( )
Allergies	( )	( )	Arthritis / Rheumatism	( )	( )
JOINT Replacement / Implant	( )	( )	Stomach Ulcer	( )	( )
Kidney Trouble	( )	( )	Tuberculosis	( )	( )
Persistent Cough	( )	( )	Chemotherapy (cancer, leukemia)	( )	( )
Sexually Transmitted Disease	( )	( )	Epilepsy / Seizures	( )	( )
Anemia	( )	( )	Glaucoma	( )	( )
Nervousness	( )	( )	Tonsillitis	( )	( )
Tumors	( )	( )	Mental Health Care	( )	( )
Back Problems	( )	( )	Chemical Dependency	( )	( )
Mitral Valve Prolapse	( )	( )	Cortisone Treatment	( )	( )
Cole Sores / Fever Blisters	( )	( )	Hypoglycemia	( )	( )
Eating Disorders	( )	( )			

Dental History

Reason for this visit? _____

When was your last dental visit? _____What was done at that time? _____

Previous Dentist (name and location) _____

Have you had any recent radiographs taken? _____ Is so, when and where? _____

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

Is your drinking water fluoridated? _____

If you could change anything about your smile, what would you change? _____

_____

Do you have or have you had the following?

	YES	NO		YES	NO
Bleeding gums while brushing or flossing	( )	( )	Sensitive to Hot/Cold	( )	( )
Sensitive to sweet /sour liquids or foods	( )	( )	Pain in any of your teeth	( )	( )
Sores / Lumps inside of your mouth	( )	( )	Clench or Grind	( )	( )
Head / Neck or Jaw injuries	( )	( )	Food caught between teeth	( )	( )
Biting lips or cheek frequently	( )	( )	Worn a bite plate of appliance	( )	( )
Following problems in your jaw:					
Clicking	( )	( )	Ever had difficult extractions	( )	( )
Pain (joint, ear, side of face)	( )	( )	Ever had prolonged bleeding	( )	( )
Difficulty opening or closing	( )	( )	Wear Partials / Dentures	( )	( )
Difficulty chewing	( )	( )	If yes, placement date _____		
Ever received oral hygiene instructions regarding the care of your teeth and gums?	( )	( )			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient or Parent / Guardian if Minor Date

Doctors Comments _____

_____

_____

Signature _____ **Date** _____

South River DENTAL CARE

Michael Billings, DDS ~ 969 Central Avenue E, Edgewater, Maryland 21037

About Financial Arrangements and Dental Insurance

Our office is committed to providing you with the best possible dental care. If you have dental ins urance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

The patient's share of payment is due at the time the services are rendered. We accept cash, check and certain credit cards. We happily help our patient's process claim forms for reimbursement but each patient is responsible for payment of any fees not paid by insurance. We do not track how much of a yearly benefit has been used.

Returned checks and balances over 30 days will be subject to additional collection fees and interest of 1.5% per month. Charges may also be made for broken appointments canceled without 24 hours' notice.

We will gladly discuss your proposed treatment plan and answer any questions relating to your insurance. You must realize, however:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that they will not cover.
3. The patient is responsible for payment whether or not services are covered by insurance.

We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. It is your responsibility to know and understand your insurance benefits. While filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility** as of the date of services is rendered. We encourage you to contact us if personal financial problems arise so that we may assist in the management of your account.

If you have any questions about this information, please ask us. Otherwise, please sign below that you understand and agree with this information.

_____ _____

Signature of Patient or Parent / Guardian if Minor Date

HIPAA Privacy Policy

Dear Patient,

Dr. Michael Billings will serve as both the HIPAA Privacy Officer and Contact Person for South River Dental Care, P.A.

In accordance with normal operations of this office, it may be necessary to release personal information about our patients to third parties such as pharmacies and insurance companies. The information may include dates and treatment given as well as identification about the patient or the patient's spouse or parent / guardian. Credit card information will be given to credit card processing organizations.

It is our policy to treat all patient information as personal. We only give out the specific information needed to accomplish a purpose in the patient's interest. We assume that the patient's authorization to submit claims for insurance coverage implies authorization to submit the information necessary to complete the form. We will not complete or submit insurance forms to anyone without their approval.

Any patient complaints regarding our treatment of PHI will be directed to Dr. Billings. Provisions exist for patients to access their approval.

Any employed person in the South River Dental Care, P.A. dental office has access to PHI and may use it for any cause in the patient's interest.

South River Dental Care, P.A. personnel may dismiss PHI among themselves or disclose such information to third parties while performing authorized duties in the patient's interest.

Personnel who violate the office's HIPAA policy may be disciplined using measures appropriate to the violation.

If Dr. Billings is informed of any violation of this policy by office personnel, he or other office personnel will take all appropriate action to mitigate any harmful effect.

The office will not take any retaliatory act against anyone involved in a HIPAA complaint as long as the complaint was made with the belief that the reported action had occurred.

This policy may be revised at any time. A copy of the current policy will always be readily available to any patient.

I have had an opportunity to read the above policy.

_____ _____

Signature of Patient or Parent / Guardian if Minor Date