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PATIENT REGISTRATION

Select the office location you are visiting:

☐ Catonsville ☐ Chesapeake ☐ Columbia ☐ Laurel ☐ Maple Lawn ☐ Nottingham ☐ Westminster

Patient Information:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ M.I. _____ Last Name _____

Sex ☐ Male ☐ Female DOB _____ Social Security # _____ Email _____

Address _____ City _____ State _____ ZIP _____

Home # _____ Cell # _____ Have you ever been a patient of our practice? ☐ Yes ☐ No

Referred By _____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ Orthodontist _____

Medical Doctor _____ Preferred Pharmacy _____ Phone # _____

Driver's Lic. # _____ Nearest relative not living with you _____ Phone # _____

Employer _____ Phone # _____ Personal Payment Type ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact _____ Phone # _____ Relation _____

Person Responsible for Account:

☐ Self *(If self, skip this section)* ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ Contact # _____ DOB _____

Address _____ City _____ State _____ ZIP _____

S.S. # _____ Employer _____ Driver's License _____

Spouse or Other Guarantor Information: *(If different from above)*

Name _____ Contact # _____ DOB _____

Address _____ City _____ State _____ ZIP _____

S.S. # _____ Employer _____ Driver's License _____

Insurance Information:

Student ☐ Full-time ☐ Part-time ☐ No

School Name and Address _____

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Legally Separated

Employed ☐ Full-time ☐ Part-time ☐ Retired ☐ No Do you belong to a PPO or HMO? ☐ Yes ☐ No

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PATIENT REGISTRATION (CONT.)

Primary Dental Insurance:

Employer _____

Address _____

Phone # _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Phone # _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ DOB _____ Sex ☐ M ☐ F

S.S. # _____ Phone # _____

Address _____

Secondary Dental Insurance:

Employer _____

Address _____

Phone # _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Phone # _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ DOB _____ Sex ☐ M ☐ F

S.S. # _____ Phone # _____

Address _____

Primary Medical Insurance:

Employer _____

Address _____

Phone # _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Phone # _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ DOB _____ Sex ☐ M ☐ F

S.S. # _____ Phone # _____

Address _____

Secondary Medical Insurance:

Employer _____

Address _____

Phone # _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Phone # _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ DOB _____ Sex ☐ M ☐ F

S.S. # _____ Phone # _____

Address _____

To our patients,

Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving.

Additionally, our training and experience go well beyond what most people think of when they think about what we do as oral surgeons.

Essentially, we can improve the quality of your life, but also your confidence and smile. We want to take a moment to understand you and your desires. Thank you for answering the following questions; your answers are for our records only and are confidential.

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HEALTH HISTORY

Reason for today's visit? _____

Height _____ Weight _____ Are you in good health? ☐ Yes ☐ No

Have there been any changes in your general health in the past year? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No

Date of last visit _____ What were you being treated for? _____

Have you had any illness, operation, or been hospitalized in the past 5 years? ☐ Yes ☐ No

If so, describe _____

Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? ☐ Yes ☐ No

If so, describe where _____

Do you have a prosthetic joint/implant? ☐ Yes ☐ No

If so, describe where _____

Have you had a heart valve replacement or vascular graft? ☐ Yes ☐ No

Have you ever had general anesthesia? ☐ Yes ☐ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

General Questions:

How is this problem affecting you? _____

Is it causing any pain or sensitivity? ☐ Yes ☐ No

Is it impacting your ability to eat what you like? ☐ Yes ☐ No

Is there anything that makes you feel self-conscious that we could assist with? ☐ Yes ☐ No

If so, describe what _____

Have you talked to any other doctors about your concerns in the past? ☐ Yes ☐ No

If so, what advice did they offer? _____

How do you envision your life after this concern is resolved? _____

Have you ever had any of the following diseases or medical problems?

Rheumatic fever? ☐ Yes ☐ No

Damaged heart valves/mitral valve prolapse? ☐ Yes ☐ No

Heart murmur? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

Low blood pressure? ☐ Yes ☐ No

Emphysema? ☐ Yes ☐ No

Do you smoke or vape? ☐ Yes ☐ No

If so, how much? _____

Do you use chewing tobacco? ☐ Yes ☐ No

Blood transfusion? ☐ Yes ☐ No

HEALTH HISTORY (CONT.)

Chest pain/angina?	☐ Yes	☐ No	Blood disorder such as anemia?	☐ Yes	☐ No
Heart attack(s)?	☐ Yes	☐ No	Bruise easily?	☐ Yes	☐ No
Irregular heart beat?	☐ Yes	☐ No	Bleeding tendency/abnormal bleeding?	☐ Yes	☐ No
Cardiac pacemaker?	☐ Yes	☐ No	Hepatitis, jaundice, or liver disease?	☐ Yes	☐ No
Heart surgery?	☐ Yes	☐ No	Infectious mononucleosis?	☐ Yes	☐ No
Pneumonia, bronchitis, chronic cough?	☐ Yes	☐ No	Gallbladder trouble?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No	Fainting spells?	☐ Yes	☐ No
Hay fever/sinus problems?	☐ Yes	☐ No	Convulsions/epilepsy?	☐ Yes	☐ No
Snoring?	☐ Yes	☐ No	Stroke?	☐ Yes	☐ No
Sleep apnea/CPAP?	☐ Yes	☐ No	Thyroid trouble?	☐ Yes	☐ No
Difficulty breathing/other lung trouble?	☐ Yes	☐ No	Diabetes?	☐ Yes	☐ No
Tuberculosis?	☐ Yes	☐ No	Low blood sugar?	☐ Yes	☐ No
Kidney trouble?	☐ Yes	☐ No	Delay in healing?	☐ Yes	☐ No
High cholesterol?	☐ Yes	☐ No	A tumor or growth?	☐ Yes	☐ No
Are you on dialysis?	☐ Yes	☐ No	Cancer/radiation therapy/chemotherapy?	☐ Yes	☐ No
Swollen ankles/arthritis/joint disease?	☐ Yes	☐ No	Chronic fatigue/night sweats?	☐ Yes	☐ No
Osteoporosis/osteopenia?	☐ Yes	☐ No	Are you on a diet?	☐ Yes	☐ No
Osteonecrosis?	☐ Yes	☐ No	A history of alcohol abuse?	☐ Yes	☐ No
Stomach ulcer/acid reflux?	☐ Yes	☐ No	A history of marijuana or other drug use?	☐ Yes	☐ No
COVID-19?	☐ Yes	☐ No	Contact lenses?	☐ Yes	☐ No
Contagious diseases?	☐ Yes	☐ No	Eye disease/glaucoma?	☐ Yes	☐ No
Sexually transmitted diseases?	☐ Yes	☐ No	Mental health problems/anxiety/depression?	☐ Yes	☐ No
Problems with immune system?	☐ Yes	☐ No	A removable dental appliance?	☐ Yes	☐ No
Autoimmune disease?	☐ Yes	☐ No	Pain or clicking of jaws when eating?	☐ Yes	☐ No

>>> Women Only:

Is there a possibility of pregnancy? ☐ Yes ☐ No

If so, what is the expected delivery date? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Are you now taking:

Any kind of medication, drug, pills? ☐ Yes ☐ No

Blood thinners (Coumadin®, Plavix®, aspirin, vitamin E, ginkgo biloba, Aggrenox®, Xarelto®, Eliquis®, fish oil)? ☐ Yes ☐ No

Have you ever taken diet pills? ☐ Yes ☐ No

Any natural product, herbal supplement, or homeopathic remedy? ☐ Yes ☐ No

Are you taking, or have you ever taken bone density meds, RANKL inhibitors, or bisphosphonates such as Prolia®, Fosamax®, Boniva®, Actonel®, IV-Zometa®, Aredia®, Reclast®, Xgeva®, or Evista® in the past 12 years? ☐ Yes ☐ No

HEALTH HISTORY (CONT.)

Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? ☐ Yes ☐ No

If so, please list _____

If you are under the care of a physician for pain management, or recovering from drug addiction, please select the medication you are currently taking ☐ Methadone ☐ Suboxone ☐ Oxycodone ☐ Fentanyl

☐ Other _____ Treating doctor _____

Please list any medications you are currently taking _____

Are you allergic to, or have you had a reaction to:

Local anesthetic (numbing medicine)?	☐ Yes	☐ No	Amoxicillin?	☐ Yes	☐ No
Penicillin?	☐ Yes	☐ No	Codeine or other narcotics?	☐ Yes	☐ No
Other antibiotics?	☐ Yes	☐ No	Latex?	☐ Yes	☐ No
Sulfa drugs?	☐ Yes	☐ No	Soy?	☐ Yes	☐ No
Sodium pentothal/Valium®/other tranquilizers?	☐ Yes	☐ No	Eggs/yolk?	☐ Yes	☐ No
Aspirin?	☐ Yes	☐ No	Sulfites?	☐ Yes	☐ No

Please list any allergies other than drug allergies

Please list any other medication or antibiotic you are allergic to

If you are having surgery **today**, have you had anything to eat or drink in the last 6 hours? ☐ Yes ☐ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ☐ Yes ☐ No

If yes, describe _____

Is there a family history of ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problems

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient (Parent or Guardian if Minor) **Doctor** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper claim forms; please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures, some may pay a percentage, and others may pay a percentage of that charge. The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company after 60 days. You will be responsible for all collection costs, attorney's fees, and court costs. We will not submit any claims to medical insurance. In the instance that we may need to use an outside lab/facility for services rendered (i.e., lab or hospital), we ask that you please provide your medical insurance information, so that we may pass it along to these facilities to expedite processing of claims on your behalf. Any outside lab/facility used may incur separate fees, and will be billed separately from our offices.

Signature of Patient (Parent or Guardian if Minor) **Date**

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FINANCIAL POLICY

Please take the time to read the following and initial each section. Sign, print, and date the bottom of this section.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary dental insurance plans, as a courtesy, at no cost to you. However, insurance balances which are not paid within 60 days will be the patient's responsibility and will be billed. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ For any biopsy services, our office uses an outside pathology lab and their services are billed separately. If there is a charge from the lab you will receive a statement from the lab in addition to services rendered by our surgeons.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our offices or by responding to our confirmation contact. Failure to confirm your appointment, and/or show up within 15 minutes of your scheduled appt. time, will result in a $130.00 no show charge for the time that is reserved for your surgical appointment.

_____ There will be a fee of $50.00 for any checks returned as Non-Sufficient Funds (NSF).

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

- **Interest charges of 1.5% per month**
- **18% APR collection fees (up to 25% of the full balance)**
- **Legal fees for collection services**

Signature of Patient (Parent or Guardian if Minor) **Date**

AUTHORIZATION

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all X-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

☐ I permit messages to be left on my phone and/or mobile phone concerning my appointment.

☐ I permit the office to communicate with me via text message on my cell phone.

Signature of Patient (Parent or Guardian if Minor) **Doctor** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient (Parent or Guardian if Minor) **Relationship to Patient** **Date**

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PATIENT CONSENT

First Name _____ M.I. _____ Last Name _____

I agree that the practice may communicate with me at the following address(es):

Phone # _____ Email _____

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

- Send a recall appointment reminder to your home . . . . . ☐ Yes ☐ No
- Leave appointment, billing, or dental information on your answering machine/voicemail/email/text . . . . ☐ Yes ☐ No

I give permission to share appointment, billing, or dental information with the person named below:

_____

Signature of Patient (Parent or Guardian if Minor) **Date**

NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how health information 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 on 12/1/2018, 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 and/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 at the end of this notice.

USES & DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use/disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use/disclose your health information to obtain payment for services we provided to you.
- **Healthcare operations:** We may use/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.

PATIENT CONSENT (CONT.)

- **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/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 of disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use/disclose your health information for any reason except those described in this notice.
- **To Your Family & 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/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, your location, your general condition, or death. If you are present, then prior to use of 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 judgement, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and 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, unless you have stated otherwise.
- **Market Related Health Services:** We will not use your health information for marketing communication without your written authorization and consent.
- **Required by Law:** We may use/disclose your health information when we are required to do so by law.
- **Abuse or Neglect:** We may use/disclose your health information to the extent necessary to avert a serious threat to your health, safety, or the health and safety of others.
- **National Security:** We may use/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 disclose to correctional institutions/law enforcement officials having lawful custody of protected health information of an inmate or patient under certain legal circumstances.
- **Appointment Reminders:** We may use/disclose your health information to provide you with appointment reminders, such as voicemails, text messages, emails, or certified letters.

PATIENT RIGHTS

- **Access:** You have the right to look at/get copies of your health information, in writing, with limited expectations. 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 a letter to the address at the end of this notice. If you request copies, we will charge you $2.00 per page, $15.00 per hour of the staff's time to locate and copy your health information. There will be additional fees to have information mailed via certified mail.
- **Disclosure Accounting:** You have the right to receive a list of instances in which we/our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and other activities, but not before 3/1/2015. 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.

PATIENT CONSENT (CONT.)

- **Restrictions:** You have the right to request that we place additional restrictions on our use/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 an alternative location. You must make a request in writing and must specify the alternative means/location and provide satisfactory explanation of how payments will be handled under the alternative means/location of your 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 website, by email, or other electronic forms, you are entitled to receive this notice in written form.
- **Questions/Complaints:** If you want more information about our privacy practices, or have questions/concerns, please contact our office.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision that we made about access to your health information in a response to a request you made to amend a decision on the use/disclosure of your health information or to have us communicate with you by alternative means/locations, you may contact the contact officer listed below. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address upon request. We will not retaliate in any way, if you choose to file a complaint with us or the U.S. Department of Health and Human services.

We support your right to the privacy of your health information.