# WELCOME
## TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

## PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

## ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

## DENTAL HISTORY

Former Dentist _____
City, State _____
Date of Last Dental Visit _____

Date of Last X-Rays _____
How Often Do You Floss? _____
How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

## MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations? | ☐ | ☐ |
| 3. Are you currently taking any medication? | ☐ | ☐ |
| Please describe: _____ | | |
| 4. Do you smoke? | ☐ | ☐ |
| 5. Do you use alcohol, cocaine or other drugs? | ☐ | ☐ |
| 6. Do you wear contact lenses? | ☐ | ☐ |

7. Have you had any allergic reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates (sleeping pills) | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Other | ☐ | ☐ |

8. (Women Only) Are You:

| | | |
|---|---|---|
| Pregnant? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ |

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

## ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Advait V. Shah, DMD
16 Greenmeadow Drive
Suite 205
Timonium, MD 21093

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

## CONSENT FOR TREATMENT

1) I hereby authorize doctor or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (Name of patient)_____'s dental needs.

2) Upon such diagnosis , I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3) I agree to the use of anesthetics, sedatives and other medication as necessary . I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complication.

4) I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. IN the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) maybe added to my account.

5) I agree that should I default and fail to make payment as agreed that I shall be responsible for all costs of collection including attorneys fee of 15% and court costs.

Patient_____Date_____Witness_____

Parent or Responsible Party_____Relationship to patient_____

# NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

ITEM 070-6025/25044 © MAY 2002

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

# NOTICE OF PRIVACY PRACTICES – HIPAA & 42 CFR PART 2

This Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected health information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health or condition, the healthcare services you receive, or payment for those services.

Some types of health information, including records related to Substance Use Disorder (SUD), receive additional protections under federal law, including regulations found at 42 CFR Part 2, in addition to HIPAA. These enhanced protections are explained later in this Notice.

## OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that your health information is personal and confidential. We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

## HOW WE MAY USE AND DISCLOSE YOUR PHI

**Treatment** – We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services.

**Payment** – We may use and disclose your PHI to obtain payment for services provided to you.

**Healthcare Operations** – We may use and disclose your PHI for practice operations, including quality assessment, staff training, legal compliance, auditing, and business planning.

**Appointment Reminders** – We may use or disclose your PHI to contact you about appointments, reminders, or treatment alternatives.

**Required by Law** – We may use or disclose your PHI when required by federal, state, or local law.

**Emergencies** – We may use or disclose your PHI in emergency situations as necessary to protect your health or safety.

**Public Health Activities** – We may disclose PHI for public health purposes, including disease prevention and reporting.

**Military, National Security, and Protective Services** – We may disclose PHI as required for military activities, national security, and protective services.

**Research** – We may use or disclose your PHI for research purposes when approved by law and with appropriate safeguards.

**Legal Proceedings** – We may only disclose PHI in response to a valid court order or other lawful process or by your written consent.

**Marketing** – We will not use your PHI for marketing purposes without your written authorization.

**Personal Representatives** – We may only disclose your PHI to a personal representative authorized by you in writing.

**Business Associates** – We may share your PHI with business associates who perform services on our behalf. These business associates are required by law to safeguard your information.

**Workers' Compensation** – We may disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

## SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS

Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD).

Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

### How SUD Information May Be Used

SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions.

### Prohibition on Legal Use

SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order.

### Redisclosure Limitations

SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules.

### Fundraising Restrictions

Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the Office for Civil Rights without retaliation

## CHANGES TO THIS NOTICE

We reserve the right to change this Notice. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request, in our office, and on our website.

# NOTICE OF PRIVACY PRACTICES
# PATIENT ACKNOWLEDGMENT

## CONTACT INFORMATION

If you have questions, would like additional information, or wish to exercise your rights, please contact:

Practice Name: _____

Address: _____

Phone Number: _____

Email (optional): _____

## PATIENT ACKNOWLEDGMENT OF NOTICE

By signing below, you acknowledge that you have received a copy of this Notice of Privacy Practices and understand your rights under HIPAA and applicable federal confidentiality laws, including special protections related to Substance Use Disorder (SUD) information.

- ☐ I acknowledge receipt of this Notice of Privacy Practices.
- ☐ I understand that SUD-related information may have additional protections.
- ☐ I understand my right to opt out of fundraising communications.
- ☐ I understand that certain disclosures may require my written authorization.
- ☐ Their SUD-related information cannot be used for fundraising without consent.

Patient Name (Print): _____

Signature: _____

Date: _____

If the patient is unable or unwilling to sign, staff should document the reason here.

| |
|---|
| |

Staff Initials: _____ Date: _____

If you believe your privacy rights have been violated, you may file a complaint with us or with OCR. You will not be penalized for filing a complaint.

Practice Privacy Officer: _____

Practice Address: _____

Phone Number: _____

Email (Opional): _____