Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

E-Mail Address:__ _____ Gender: ____ Family Status: ___

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Joint replacement
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Currently **Pregnant** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ **Latex** Allergy
- ☐ Local Anesthetic
- ☐ Are you currently taking **ASPRIN**?
- ☐ Over the counter Meds
- ☐ **NO CHANGE**
- ☐ **Have you recently traveled to the following countries: Guinea, Sierra Leone or Liberia?**
- ☐ **Have you ever been Abused?**

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any medications, Including **ASPRIN** or **Blood thinner medications**? If so please list all of them,

_____

- In case of emergency please contact: Name:_____
Number:_____Relationship:_____

To The best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐Relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

Name: _____

☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of treatment by this office, I agree to allow all necessary dental radiographs and comprehensive exam by the doctor. I understand that if I do not agree with these terms, that the doctor can not make a diagnosis of my dental condition, oral health and treatment plan of necessary dental treatment needed to bring me to good oral health to standards and guidelines put forth by the Academy of General Dentistry and University of Maryland Dental School.

I have read the above conditions of treatment to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Greenbelt Dental Associates, LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: _____

Address: _____

Telephone:_____

Social Security #: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We will report any abuse and neglect to the proper authorities.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Greenbelt Dental Associates, LLC 7500 Greenway Center Drive Greenbelt, MD 20770 301.474.2505

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Greenbelt Dental Associates, LLC

7500 Greenway Center Drive, Suite 120
Greenbelt, MD 20770

Office Financial Policy

Thank you for choosing our office to serve your dental needs. We strive to provide the highest quality treatment at a reasonable cost to you. The following is a statement of our financial policy. Please read this document very carefully and sign below:

We have listed our payment options below for your convenience:

Cash, VISA, MasterCard-(minimum $10.00),Personal checks, Care Credit, On line bill payments at WWW.Bestdentalcare.us .

****

We expect insured patients to read their policies carefully. It is very important that you are familiar with its benefits and limitations. We will accept assignment of benefits provided the necessary documentation has been provided. **We do require that you pay your deductible and/or estimated co-pay at the time of service**. **If your insurance company has not paid your account in full within 45 days of treatment or denies your claim for ANY reason, you are responsible for the total balance.** For patients with dual insurance policies we will file your primary insurance claim we and will submit a claim for your secondary, but you are still responsible for any payment not paid by your insurance.

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All prosthetic services **must be paid in full on or before completion**.

We reserve the right to charge any account balance due **over 60 days a 18% Yearly Finance Charge** or a $5.00 repeat billing charge, whichever is greater. (Including payment plans.)

If your account is turned over for collection, you agree to pay any reasonable collection fees (25% is deemed reasonable) **If suit is filed, you agree to pay reasonable Attorneys fees (33.3% is deemed reasonable) court costs, and other expenses incurred as a result of said collection.** You agree that should suit be filed, venue (location of suit) shall be Prince Georges County, Maryland, venue in any other counties being waived hereby.

We consider the parent or guardian who brings the child to our office for treatment the responsible party for payment of the child's account. If someone else is legally responsible for the child's account, it remains the responsibility of the parent or guardian bringing the child in for treatment to seek reimbursement for payment made to our office.

The office reserves the right to charge $45.00 per half hour for canceling appointments, missed, or rescheduling less than 48 hrs., maximum $100. To avoid a charge, 2-business days notice must be given. All dental appointments MUST BE CONFIRMED. If an appointment is unconfirmed 24 hours prior to your appointment, your appointment time will be given to another patient.

A $10 Admin fee, billed semiannually for $20 max yearly.

A $25.00 fee will be assessed for the duplication of records/x-rays.

A $37.00 fee will be added to your account for any checks returned to us by the bank.

If your insurance pays less than estimated, you will be billed any balance due regardless of any treatment plan estimate presented.

Any patient arriving 15 minutes past their appointment time, will may e asked to reschedule.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid for by my dental benefits plans, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payments of the dental benefits otherwise payable to me, directly to Greenbelt Dental Associates, LLC. I also authorized the practice to submit claim disputes to the Maryland Insurance commission on my behalf.

I have read and agree to the terms in this Office Financial Policy.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Printed Name of Patient