

Welcome

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

Patient Information

Name _____
Last First MI

Parent / Gardian _____

Male Female Single Married Other

Birthdate _____ SSN _____

Driver's License _____ State _____
(photocopy required)

Address _____

City _____ State _____ Zip _____

H Phone _____ Cell _____

E-mail _____

Employer _____ Wk Phone _____

Emergency Contact _____

Emergency Phone _____

How did you hear about us? _____

Insurance Information

Name of Insured _____

Insured's SSN _____ DOB _____

Insurance Company _____ Phone _____

Employer _____ Group _____

Insured's Relationship to Patient _____

School (full-time students) _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to the office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use for this signature on all insurance submissions.

Responsible Party Signature _____

Relationship to Patient _____ Date _____

Office Policies

We have established the following office policies. Please place your initials by each to indicate that you have read them.

_____ Payment and/or co-payment is required in full at the time of services are provided.

_____ A \$10 infection control fee is charged for each visit. This fee covers the disposable items and the sterilization and disinfectant technology involved in your visits as required by law (OSHA).

_____ At least 48 hours advance notice is required for all appointment changes or cancellations. Otherwise, a \$25 fee is charged for each appointment so affected; an additional \$25 cancellation fee is charged for appointments with specialists.

_____ If you have any questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations. **Please not that dental insurance is very different from medical insurance and that in most cases a co-payment is required.**

_____ Please be advised that the co-payment requested for services rendered is **only an estimate** of what the insurance will not cover, as determined from the information provided by the insurance company. The information given to our office is **not a guarantee of payment**, and the actual insurance benefit may differ from our estimates. **The account holder is responsible for all charges the insurance company does not pay within 45 days.**

_____ Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged directly by that company.

_____ Past due accounts (having a balance due for more than 60 days) will be charged 1.5% interest per month until account is reconciled. Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency or the Maryland State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

X

Responsible Party Signature _____

Date _____

Over Please ...

Dental Health History

Name: _____

Reason for today's visit _____

Former Dentist _____

Phone _____

Date of last dental exam _____

Date of last dental x-rays _____

Date of last cleaning _____

How often do you brush? _____

How often do you floss? _____

Do you feel pain anywhere? _____

Describe _____

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Sensitivity to hot or cold Yes No
Sensitivity to sweet Yes No

Avoid one side of the mouth when chewing Yes No
Sensitivity when biting Yes No

Broken / cracked fillings Yes No
Food collection between teeth Yes No

Tobacco use Yes No

Gums swollen or tender Yes No
Gums bleed frequently Yes No

Blisters on lips or mouth Yes No
Sores or growths inside cheek / in the mouth Yes No

Bad breath Yes No
Burning sensation on tongue Yes No
Dry mouth Yes No

Accident involving jaw Yes No

Clicking or popping jaw Yes No
Frequent headaches Yes No
Grinding teeth Yes No
Jaw pain or tiredness Yes No
Pain around ear Yes No

Orthodontic treatment Yes No
Periodontal treatment Yes No

Medical Health History

Physician _____ Phone _____

Please list all current medications (including prescription, over-the-counter, herbal supplements) and reason for use:

Are you allergic to any of the following?

Aspirin Codeine Latex Penicillin Valium

Other: _____

Have you ever had any of the following conditions?

Artificial joint/valve Heart murmur Mitral valve prolapsed Rheumatic fever

Women Only:

Do you use birth control medication? Yes No

Are you nursing? Yes No

Are you pregnant? (Due date: _____) Yes No

Circle "Yes" or "No" to indicate whether you have Had any of the following conditions:

AIDS / HIV Yes No

Anemia Yes No

Arthritis or Back problems Yes No

Asthma or Respiratory problems Yes No

Blood transfusion (Date: _____) Yes No

Cancer Yes No

Cardiac pacemaker Yes No

Convulsions / Epilepsy / Seizures Yes No

Diabetes Yes No

Excessive bleeding with surgery / extractions Yes No

Heart problems Yes No

Hepatitis or Liver problems Yes No

High or Low blood pressure Yes No

Kidney problems Yes No

Phen-Phen treatments Yes No

Radiation or Chemotherapy treatment Yes No

Sexually transmitted disease Yes No

Stroke Yes No

Thyroid disorder Yes No

Tuberculosis Yes No

Other: _____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

Date _____

Responsible Party Signature _____

Date _____

Attending Dentist Signature _____

KENTLANDS DENTAL CARE

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 April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this office 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 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 use open bay operatories for treatment. There are no walls separating each operatory, if this setting is not to your liking please let the receptionist so that other arrangements can be made if possible. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information of 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 of 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 in writing 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 or 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 your 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 your 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 or 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, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmates or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, 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. We 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 the address at the end of this Notice. **If you request copies, we will charge you \$22 for copies of you 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 at the end of this Notice 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 or 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.

Kentlands Dental Care
237 Kentlands Boulevard
Gaithersburg, MD 20878
301-987-5200

KENTLANDS DENTAL CARE

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

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 Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

Kentlands Dental Care

237 Kentlands Blvd. | Gaithersburg MD, 20878 | 301-987-5200

FINANCIAL POLICY

Thank you for choosing Kentlands Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Please choose one of the following payment options:

I do not have dental insurance and:

- I would like to pay by cash or check
- I would like to pay by credit card
- I would like to apply for an extended NO INTEREST¹ Payment Plan² from CareCredit or Capital One
 - o Allow you to pay over time with NO INTEREST¹
 - o Convenient, low monthly payment plans² also available
 - o No annual fees or pre-payment penalties

I have dental insurance and:

- I would like to pay my estimated portion by cash or check
- I would like to pay my estimated portion by credit card
- I would like to apply for an extended NO INTEREST¹ Payment Plan² from CareCredit or Capital One
 - o Allow you to pay over time with NO INTEREST¹
 - o Convenient, low monthly payment plans² also available
 - o No annual fees or pre-payment penalties

We have established the following Financial Policies. Please place your initials by each to indicate that you have read them.

___ **Kentlands Dental Care requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.**

___ **In order to reserve time with the Doctors we require your payment at the time the reservation is made. For larger more extensive treatment plans a 50% deposit is required to secure the initial appointment.**

___ As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered. Please remember that the contract is between you and your insurance company, and **your total balance in our office is always your responsibility**. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.

___ Acceptance of partial payment for services rendered is a courtesy extended to our patients. If, for any reason, your insurance does not pay for the services rendered by Kentlands Dental Care, you, the

patient, are solely responsible for the balance in full. You are ultimately responsible for knowing and understanding your policy, its benefits, exclusions and limitations.

___ We will only pursue Insurance payments for 60 days after that you, the patient, are ultimate responsible for your balance with Kentlands Dental care. We will be happy to assist you in contacting your insurance company.

___ Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency or the Maryland State Clerk of Courts. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

___ At least 48 hours advance notice is required for all appointment changes or cancellations. Otherwise, a \$25 fee is charged for each appointment so affected; and additional \$25 cancellation fee is charged for appointments with specialists and/or any lengthy treatment requiring a reservation of more than an hour.

___ Kentlands Dental Care charges \$34 for Returned Checks.

___ We are always willing to work through unusual situations and accommodate our patients in any way possible. We are here to help you get the dentistry you want or need. If you have any questions or concerns regarding our financial policies please see one of our treatment coordinators prior to beginning treatment.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.