Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Email: _____

Home Address: _____

Phone: H: _____ W: _____ C:_____

(Circle Preferred Contact Number)

Marital Status: _____

Employer's Name: _____ Occupation: _____

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

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Primary Dental Insurance Information

Name of Insured: _____Subscriber Date of Birth: _____

Relationship to Patient: _____ Insurance Carrier: _____

Address:_____

Subscriber ID #: _____ Group #:_____

Subscribers Employer: _____

Secondary Dental Insurance Information

Name of Insured: _____Subscriber Date of Birth: _____

Relationship to Patient: _____ Insurance Carrier: _____

Address:_____

Subscriber ID #: _____ Group #:_____ _____

Subscribers Employer: _____

Whom may we thank for referring you today? _____

David Billings, DDS ~ 8191 Jennifer Lane, Suite 250B, Owings, MD 20736

Health Information

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 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 controlled substances? _____

9) Are you wearing contact lenses? _____

WOMEN ONLY

10) Are you pregnant? _____

11) Are you nursing? _____

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

__Penicillin __Codeine __Anesthetic __Aspirin __Sulfa __Erythromycin __Latex __Jewelry/Metals

__Other - List, _____

Please circle if you have or have you had the following?

Heart problems	Asthma or Hay Fever	JOINT Replacement/Implant
Heart murmur	Fainting / Dizzy Spells	Kidney Trouble
High/Low Blood Pressure	Diabetes	Tuberculosis
Hepatitis	AIDS / HIV	Cancer
Jaundice	Thyroid Problems	Sexually Transmitted Disease
Stroke	Arthritis	Epilepsy/Seizures
Psychiatric care	Rheumatic Fever	Glaucoma

Consent for Services

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs occurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental service performed without prior financial arrangements must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service fee of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to the doctor, or his assignee at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree, in the event that, either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred, including reasonable attorney's fees.

It is our policy to charge $15 per 15 minutes for missed appointments without 24-hour notice. This fee must be paid prior to scheduling any further appointments.

I grant my permission to you, or your assignee, to telephone me at home, work or cellular to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____

Signature of Responsible Party/Parent or Guardian Date Relationship to Patient

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 me 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 Responsible Party/Parent or Guardian Date

HIPAA Privacy Policy

Dear Patient,

Dr. David Billings will serve as both the HIPAA Privacy Officer and Contact Person for this office.

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 this dental office has access to PHI and may use it for any cause in the patient's interest.

Office 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