DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ______________ Zip ______________

Sex ☐ M ☐ F Age ______________

Birthdate ______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________ CELL PHONE: ______________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

3 PHONE NUMBERS

Home (______) ______________ Work (______) ______________ Ext ______ Cell Phone (______) ______________

EMAIL: ______________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone (______) ______________ Work Phone (______) ______________

4 DENTAL HISTORY

Reason for today's visit ______________________

____

Former Dentist ______________________

City/State ______________________

Date of last dental visit ______________________

Date of last dental X-rays ______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ______________

How often do you brush? ______________

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5 HEALTH HISTORY

Physician's Name ______________________________ Date of last visit__________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type ________	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date______________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name______________________________

Phone (_____) ______________________________

ALLERGIES

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other______________
☐ Latex

____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications?__________ If so, what?______________________________

Patient's Signature ______________________________ Date__________

Doctor's Signature ______________________________ Date__________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications?__________ If so, what?______________________________

Patient's Signature ______________________________ Date__________

Doctor's Signature ______________________________ Date__________

Scott M. Novak, D.D.S. 505 Kerr Ave. Denton, MD 21629 410-479-0600 midshoredental.com

Office Policy

Appointments: Your appointment is scheduled specifically for your dental needs. ***A 48 hour notice during business hours*** is required to change or cancel an appointment. We will call in advance to confirm your appointment and we ***require all*** appointments to be confirmed. If your appointment is not confirmed we reserve the right to cancel. A minimum charge of $45.00 will be billed to you and must be paid prior to another appointment being scheduled for appointments missed or canceled without notice. This charge does not fully offset the financial loss or the loss of time which could have been used to treat another patient. Continual missed appointments, late arrivals or cancellations without notice ***will*** result in dismissal from the practice. For contracted dental plans (Maryland Healthy Smiles) in which a charge is not allowed, appointments will not be rescheduled. NO EXCEPTIONS! *(Initial_____)*

Insurance: Proof of Insurance is required in order to submit dental claims to your insurance company. All co-payments and deductibles are due in full the time of service. ***It is each patient's responsibility to track benefits used.*** Once benefits are exhausted, your plan will not pay for any procedures and you will be responsible for payment. This information can be found on your explanation of dental benefits or by calling the insurance company. *(Initial______)*

Payment & Collections: Payment for treatment is due on the date that services are rendered. We accept Cash, Checks, Money Orders, Major Credit Cards & Care Credit. Any amount not covered by your insurance must be paid within 15 days of the statement date. Forms are available for authorizing direct debit from your credit/debit card after insurance has paid. .If you "pre-pay" for dental services by credit/debit card and elect not to follow through with the treatment and request a refund, a minimum of 5% will be deducted from the amount you paid to cover the expenses charged by the credit/debit card company. *(Initial______)*

**Unpaid accounts over 90 days will be referred for collections at a minimum rate of 35% added to the balance owed. Patients are responsible for all collection fees, attorney fees and court costs incurred. All court cases will be processed in Caroline County. Once an account is referred for collections and you choose to continue treatment with our office, your account must be satisfied and treatment will be on a cash basis regardless of insurance status. We will gladly file your claim for reimbursement to you. *(Initial______)*

Interest- A rate of 2% (allowed by the State of Maryland) interest will be added monthly to the balance on all accounts over 30 days until the account is satisfied or referred for collections. *(Initial______)*

Statement/ Billing Fee- A $5.00 monthly fee will be applied to accounts over 30 days when a statement is generated to cover the administrative costs of copying, mailing, etc. *(Initial______)*

Returned Checks: Checks returned to us by your financial institution will be subject to a $35.00 fee and legal collection action. *(Initial______)*

Records Copying/Transfer Fee- $10.00 per patient. Please allow us 72 hours' notice to process this request for retrieval, preparation and copying of the documents. Originals and previous doctor's records will not be released from the practice and will be maintained in our office per the guidelines of the State of Maryland. *(Initial______)*

Consent for Services for Adults : All adult patients are financially responsible for their own treatment. If the subscriber of the insurance is anyone other than you, once coverage is verified, insurance will be billed. Please be advised that you, not the policy holder, are financially responsible for balances not paid by the insurance. *(Initial______)*

Consent for Services for Minors (Age 18 & under): The parent/guardian accompanying the minor will be financially responsible for all treatment, fees and payment. We will not bill another party for the services. As the responsible party, you are required to provide us with your name, address, date of birth, SS#, employer name and address. If the minor has insurance coverage under another person, the following information will be required: proof of insurance, the subscribers name, address, phone, date of birth, SS# and employer name and address. Once coverage is verified, we will gladly treat the patient. Parent/Guardians must be present with minor patients for all treatment and will be given a pediatric consent form to sign pertaining to treatment being rendered at that appointment. *(Initial______)*

Patient Accounts: Patient accounts must be paid in full from previous treatment before beginning new treatment or before the next scheduled routine appointment. This allows us to keep our fees as reasonable as possible and to continue to provide the quality of dental care that our patients deserve. *(Initial______)*

I consent to treatment for the patient indicated below, accept financial responsibility for all amounts due arising from the services provided by this office to the patient named below. With requirements and guidelines continually changing, I agree that I may be asked to periodically update my Dental Registration, HIPAA/Consent, Office Policy, etc. ,agree to inform the office of any changes in patients' health history, insurance, address and phone numbers at each appointment and will not hold the office responsible for any errors or omissions that I may have made in the competition of these forms. I agree that this office policy will take place of all previous office policies, may be updated at any time and refusal to complete/sign any of these forms may result in the office refusing to provide treatment.

*******I have read the above, initialed and agree to its content.******

_______________________________ _______________________________ __________

Patient Name (Please Print Patient Signature (parent/guardian of minor) Date

_______________________________ __________

Witness Signature Date

Rev: January 2016

Scott M. Novak, D.D.S.
Consent for Treatment and for Use and Disclosure of Health Information
&
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:____

Full Address:____

Telephone :____________________SS#______________________DOB :______________

TO THE PATIENT- Please read the following statement 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.

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 reserve the right to change our privacy practices as described on our Notice of Privacy Practices. If we change our policy 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.

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 below. Please understand that revocation of the 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.

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

Contact Person: HIPAA Compliance Officer
Address: 505 Kerr Ave, Denton, MD 21629 Phone: 410-479-0600

I have had full opportunity to read and consider the contents of this Consent form and have read and received your Notice of Privacy Practices.

Signature:____Date:________________

(Patient, Personal Representative, or Parent/Guardian for Minor) (Seal) (Seal)

For Office Use Only

Attempt was made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ a. Individual refused to sign
___ b. Communications barriers prohibited obtaining the acknowledgement.
___ c. An emergency situation prevented us from obtaining acknowledgement.
___ d. Other (Please specify)

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Patient Authorization for E-Mail, Text Messaging & Telephone Transmission

Effective November 17, 2015, we are happy to provide our patients with the opportunity to participate in our new patient communication system. *Some of the features include the ability to:*

*Receive text message and email appointment reminders.
*Confirm your appointment via e-mail and text message.
*Request appointments via email.
*Email or text message correspondence (including but not limited to treatment notes, x-rays, etc.) to any referring specialist.
*Receive and respond to our patient satisfaction surveys.

Please provide us with your contact information printing neatly and legibly.

Patient Name:____

Cell Phone:____

Email:____

Home Phone:____

We strongly believe in protecting the privacy of our patients. When you provide this information to us, it will be strictly used for the purpose of communicating with you more efficiently. This consent includes all minor (under age 18) patients listed under the guarantor of the account and only parents/guardians will be contacted regarding dental appointments for minors.

I,______________________________, have had the opportunity to ask questions and have had them answered to my satisfaction. I give Dr. Novak's office permission to contact me via text message, e-mail and telephone. I agree to immediately alert the office to any changes to my phone numbers and/or email address. In the event that I chose to revoke this consent, I will submit my request to the office in writing.

____
Signature Date

____
Witness Date