DENTAL HEALTH HISTORY

CONFIDENTIAL

.Today's Date _____

Patient Name_____ Preferred name _____ Birthdate_____

SSN_____ Cell/Home Phone #_____ Text Message Reminders Y N

Email_____

Street Address _____City _____State_____Zip_____

Insurance Policyholder Name_____ Insurance Carrier_____

ID Number _____Policyholder's birthdate_____ Policyholder's SSN_____

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental X-rays_____

Check (V) if you have had problems with any of the following:

☐Bad Breath	☐Grinding teeth	☐Dry mouth/ Xerostomia
☐Bleeding gums	☐Loose teeth or broken fillings	☐Sensitivity to sweets
☐Clicking or popping jaw	☐Periodontal treatment	☐Sensitivity when biting
☐Food collection between teeth	☐Sensitivity to hot/cold	☐Sores or growths in your mouth

How often do you floss? _____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of last visit _____

Have you had any serious illnesses or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates_____

Have you ever taken any of the group of drugs collectively referred to as bisphosphonates? These include Fosamax, Boniva, Prolia and Zometa? ☐Yes ☐No

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control? ☐Yes ☐No

Check (V) if you have or have had any of the following:

☐Anemia	☐Cortisone Treatments	☐Hepatitis	☐Scarlet Fever
☐Arthritis, Rheumatism	☐Cough, Persistent	☐High Blood Pressure	☐Shortness of Breath
☐Artificial Heart Valves	☐Cough up Blood	☐HIV/AIDS	☐Skin Rash
☐Artificial Joints	☐Diabetes	☐Jaw Pain	☐Stroke
☐Asthma	☐Epilepsy/Seizures	☐Kidney Disease	☐Swelling of Feet or Ankles
☐Back Problems	☐Fainting	☐Liver Disease	☐Thyroid Problems
☐Blood Disease	☐Glaucoma	☐Sleep Apnea	☐Tobacco Habit
☐Cancer	☐Headaches	☐Pacemaker	☐Tonsillitis
☐Chemical Dependency	☐Heart Murmur/MVP	☐Radiation Treatment	☐Tuberculosis
☐Chemotherapy	☐Heart Problems	☐Respiratory Disease	☐Ulcer
☐Circulatory Problems	☐Hemophilia	☐Rheumatic Fever	☐Venereal Disease/Herpes Virus

MEDICATIONS

List medications you are currently taking:_____

_____

Pharmacy Name_____

Phone #_____

ALLERGIES

☐Aspirin ☐Penicillin

☐Barbiturates (sleeping pills) ☐Sulfa

☐Codeine ☐Latex

☐Local Anesthetic ☐Other_____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Guardian or Personal Representative Relationship to Patient

Patuxent River Dental Care
Office Policy and Financial Agreement

Patuxent River Dental Care will honor presented fees for up to 60 days without notice with the understanding that nothing has changed in the conditions of teeth since treatment was planned. We reserve the right to change procedure fees after 60 days of presented plans with or without notice to patients. We stand behind our treatment only when the patient is seen on a regular basis and is under our regular care every six months or as recommended by the doctor.

I hereby authorize Patuxent River Dental Care to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regards to my insurance coverage is correct. I further authorize the release of any information, including medical and dental information for this or any related claim to my insurance carrier. Once insurance maximum benefits have been reached, we reserve the right to charge procedures at our usual customary and reasonable fees previously set by the corporation. Patients agree and understand that Patuxent River Dental Care estimate fees to the best of our ability and is never a guarantee of benefits and upon review by the insurance companies contracted charges could change without notice. No refunds will be given until all claims have been paid by the insurance company.

I understand and agree that I am financially responsible for charges not paid by my insurance company. Charges not paid within 90 days by insurance company will be made "***patient responsible***". I further agree in the event of non-payment, to be responsible for the cost of collections, and or court costs and any reasonable legal fees.

At Patuxent River Dental Care, it is the policy that, any work that will require an hour appointment and/or may cost more than $500.00 will require a deposit of 30% of treatment total cost to reserve your appointment and the balance due day of prior to appointment. As well as, in the event of no call no show there is a $50.00 fee for cleaning appointment and $100 for schedule doctor appointments.

In an effort to make sure all Patuxent River Dental Care patients, as well as staff, are treated with courtesy and respect, I hereby understand and agree in the event I arrive 15 minutes late to my appointment, Patuxent River Dental Care has the right to reschedule my appointment when there is availability.

Patient Signature:_____ Date:

Print Patient Name:_____

COVID-19 Dental Treatment Consent Form

I,_____ consent to have dental treatment during the ease out of the COVID-19 pandemic at this office. I have also been verbally informed of the risks (Initial)

_____ I confirm that I am not presenting with any of the following symptoms of (initial)

COVID-19 listed below:

-Fever -Dry Cough -Shortness of Breath -Runny Nose

- Sudden loss of taste or smell -Sore Throat

_____
(initial)

I verify that I have not traveled outside USA in the past 14 days. And that I have been following the self- quarantine and social distancing guidelines for the past 14 days minimum. I also have not been exposed to a CORONAVIRUS positive patient in the last 14 days, to the best of my knowledge.

_____
(initial)

I understand that this office screens all patients and staff for possible COVID-19 infection per the current guidelines. However, carriers of the virus may be completely asymptomatic and still be contagious. Some fever may develop full blown symptoms. Presently, it is impossible to determine who is an asymptomatic carrier. While this office strictly adheres to the CDC/OSHA/WISHA standards as they currently exist, Coronavirus is a new, highly contagious pathogen that can be transmitted to and from healthcare workers even under strictly followed CDC/OSHA/WiSHA standards. This Virus can be spread through droplets of contact. Additionally, certain Dental procedures create water mist (aerosol) which is one way the virus is spread. The aerosol and thus the virus can linger in the air for hours after certain dental procedures.

_____
(initial)

I understand that due to other dental patients visiting the office and due io the characteristics of the virus and dental procedures, I have an elevated risk of contracting the virus simply by being in a dental office.

_____
(initial)

I understand the CDC recommends social distancing of at least 6 feet, and this is not possible when seeking dental care.

Signature:_____ Date: _____

HIPAA -Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

(Print Name)	Relationship
(Print Name)	Relationship
(Print Name)	Relationship

.ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I understand that if my personal health information (phi) is required to be transferred via email or in any capacity, said email **will not be encrypted** by Patuxent River Dental Care and I do not hold Patuxent River Dental Care accountable for potential loss or misuse of my phi.

_____I have received a copy of this office's Notice of Privacy Practices.

_____ I refused to receive a copy

(Print Name)	(Date)
(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)

HIPAA Notice of Privacy Practices

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.

About This Notice

This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

How We May Use and Disclose Your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

For Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

For Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for hospital admission.

For Health Care Operations
We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services
We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Fundraising Activities
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

Plan Sponsors
If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

Facility Directories
Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people

that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Business Associates
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

For Data Breach Notification Purposes
We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan, if applicable, through which you receive coverage.

Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

Your Rights Regarding Health Information About You

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

This office is not required to agree to a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket. If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to receive notice of a security breach. We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Complaints or Questions

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. You may reach our office by calling: (_____) _____.
Telephone

If you have a question about this privacy notice, please contact our Privacy Officer at: (_____) _____.
Telephone

Effective Date: This notice is effective as of 9/23/2013.