ROBINWOOD DENTAL CENTER

11110 Medical Campus Road Suite 148 Hagerstown, MD 21742
robinwooddentalcenter.com

PATIENT INFORMATION

____ _____/______/_______ F/M
Last First Middle Initial Date of Birth Sex

____
Street City State Zip Code

_______/______/_________ _____-______-_______ _____-_____-______ _____-______-______
***Required Social Security Number** Home Telephone Work Telephone Cell Telephone

____
Email

___________________________ ____
Employer Emergency Contact, Name and Telephone Number

FT College student ____________________ Marital Status M/S/D/W ___________________
Name of college Referred By

PRIMARY DENTAL INSURANCE INFORMATION

________________________ _________________________ ______/_______/_________
Subscriber's Name **Subscriber's** ID Number **Subscriber's** Date of Birth

____
Dental Insurance Name, Address and Telephone Number

___________________________ ____________ Self Spouse Child Other
Subscriber Place of Employment Group Number Patient Relationship to Subscriber

SECONDARY DENTAL INSURANCE INFORMATION

________________________ _________________________ ______/_______/_________
Subscriber's Name **Subscriber's** ID Number **Subscriber's** Date of Birth

____
Dental Insurance Name, Address and Telephone Number

___________________________ ____________ Self Spouse Child Other
Subscriber Place of Employment Group Number Patient Relationship to Subscriber

Continue on reverse side…

DENTAL HISTORY

____ ________________________
Previous Dentist Name and Telephone Number — Date of last dental visit

____ ________________________
Purpose of last dental visit — Date of last dental x-rays

____
Purpose of your visit today

Would you like to speak with the Doctor privately about any problem? ___yes ___no

Please X if you have any of the following:

__Breath odor
__Bleeding Gums
__Clicking or Popping Jaw
__Broken fillings
__Grinding teeth
__Loose teeth
__Periodontal treatment
__Sores or growths in mouth
__Food Collection between teeth
__Sensitivity to hot and/or cold
__Sensitivity to sweets
__Sensitivity while biting

MEDICAL HISTORY

____________________________ ______-________-_________
Name of **Physician** — Telephone Number

Have you ever had any serious illnesses or operations? ___yes ___no

If yes, please describe____

Have you ever had a blood transfusion? ___yes ___no

If yes, approximate date____

Women

Are you pregnant? ___yes ___no Nursing? ___yes ___no Taking Birth Control Pills? ___yes ___no

Please X if you have or have had any of the following:

__AIDS/HIV Positive
__Anemia
__Arthritis/Rheumatism
__Artificial Heart Valve
__Artificial Joints
__Asthma
__Back Problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatment
__Cough, Persistent
__Cough up blood
__Diabetes
__Epilepsy
__Fainting
__Glaucoma
__High Blood Pressure
__Heart Murmur
__Heart Problems
__Hemophilia
__Hepatitis
__ Migraines
__Jaw Pain
__Kidney Disease
__Latex Allergy
__Liver Disease
__Mitral Valve Prolapse
__Nervous Problems
__Pacemaker
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__ Shortness of Breath
__ Skin Rash
__ Smoke/Tobacco Habit
__ Thyroid Problems
__ Tonsillitis
__Tuberculosis
__ Ulcer
__ Osteoporosis
__ Biophosphonates

Do you have any disease, condition, or problem not listed? If so, please explain:

____

List any medications you are taking:

____
____
____

List any medications you are allergic to:

____
____
____

***I certify that the above information is complete and accurate*.**

____ ______/______/_______
Patient/Guardian's Signature — Date

FINANCIAL POLICY

I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I agree to pay for services rendered on the day of service. If dental insurance is involved, I agree to pay my estimated patient portion, including any deductibles that may apply.

I understand that if billing arrangements are necessary, there will be a credit report obtained and any such arrangements must be agreed upon by the business office prior to services being rendered. If billing arrangements are made and I choose not to pay my account within 30 days, I agree to pay the interest charges accrued on the unpaid balance of my account up to 1.5% per month. I understand that after 90 days if I have not paid my agreed upon billing arrangements my account may be turned over to an attorney and/or collection agency. I agree to pay any and all collection fees and am aware that the collection fee could be up to 50% of the past due balance in addition to the balance already due on the account.

There are many procedures that insurance companies don't cover. Our office does only composite resin restorations (white fillings). Most insurance companies will only pay for amalgam fillings (silver fillings) on posterior (molar) teeth. You will be responsible to pay the difference. It is your responsibility to know what your insurance covers.

You will receive a courtesy call. Please listen carefully and follow the prompts to confirm your appointment. Robinwood Dental Center reserves the right to charge **$25 for each half hour** appointment cancelled or missed **without 24 hours advance notice. Patients** who **arrive late** for appointments may **need to be rescheduled.**

I have read and understand the above statements and I agree to be responsible for my balance after insurance pays their portion.
I AGREE TO ACCEPT ALL FINANCIAL RESPONSIBILITY AS STATED ABOVE FOR DENTAL SERVICES.

____ _____/______/_____
Signature of Financially Responsible Person Date

Continue on reverse side…

ROBINWOOD DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT NAME GIVING CONSENT (IF MINOR , adult please sign bottom of form)

Name: ____

Address: ____

Telephone: ______________________ E-mail: ______________________

Social Security Number: ______________________

SECTION B: TO THE PATIENT—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.

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:

Contact Person: Dawn Thomas

Telephone: (240)313-9660 Fax: (240)313-9661

Address: 11110 Medical Campus Road, #148, Hagerstown, MD 21742

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.

PRINT SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices and have received a copy for my personal records. 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.
Include completed Consent in the patient's chart.

IF YOU DO NOT WANT US TO BILL, CONTACT YOUR INSURANCE COMPANY OR ANY OTHER HEALTHCARE OFFICE FILL OUT BOTTOM OF FORM.

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: ____________________

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)

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