

ROBINWOOD DENTAL CENTER

11110 Medical Campus Road Suite 148 Hagerstown, Md 21742

PATIENT INFORMATION

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

Street City State Zip Code

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

Employer Emergency Contact, Name and Telephone Number

FT College student _____ Name of college: _____

Referred By: _____ Marital Status M / S / D / W _____

DENTAL INSURANCE INFORMATION

_____/_____/_____
Subscriber's Name Subscriber's ID Number Subscriber's Date of Birth

Dental Insurance Name, Address and Telephone Number

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

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.

I AGREE TO ACCEPT ALL FINANCIAL RESPONSIBILITY AS STATED ABOVE FOR DENTAL SERVICES.

_____/_____/_____
Signature of Financially Responsible Person Date **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:

<input type="checkbox"/> Breath odor	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Food Collection between teeth
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Sensitivity to hot and/or cold
<input type="checkbox"/> Clicking or Popping Jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Broken fillings	<input type="checkbox"/> Sores or growths in mouth	<input type="checkbox"/> 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:

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Migraines	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Cough up blood	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Smoke/Tobacco Habit
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Radiation Treatment	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease	
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	

Do you have any disease, condition, or problem not listed? Is 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

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.

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.**

REVOCACTION 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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Suite 148

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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. We would recommend that you talk with your insurance company and encourage them to change their policy. 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** of an appointment time cancelled or missed **without 24 hours advance notice.**

I have read and understand the above statements and I agree to be responsible for my balance after insurance pays their portion.

X

Signature

X

Date