8600 Lasalle Road Ste 507 Towson, MD 21286
Phone: 410.321.8480

Sweet Tooth DENTISTRY

sweettoothtowson@gmail.com
www.towsonmddentist.com

PATIENT INFORMATION

Patient Information: _____ (Last Name) _____ (First Name) _____ (MI) _____ (preferred name) Sex: M ☐ F ☐

Marital Status: _____ (please select one) Birth Date: _____ (mm/dd/yyyy) SSN _____

Dependant Student Status: Full Time ☐ Part Time ☐ Name of School _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone Numbers: ( ) _____ (Home) ( ) _____ (Work) ( ) _____ (Cell)

Email: _____

Preferred Contact Method: Phone ☐ _____ (please select one) Email ☐ Text ☐ _____ (name of wireless carrier)

Emergency Contact Person: _____ (Name) _____ (Phone)

Whom may we thank for referring you to our practice? _____

INSURANCE INFORMATION

Insurance Subscriber: _____ Birth Date: _____ (mm/dd/yyyy)

Is subscriber a Patient? Yes ☐ No ☐

Subscriber's SSN _____ Subscriber's ID# _____

Subscriber's Address: (if different) _____ (Street) _____ (Town) _____ (State) _____ (Zip)

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other _____

Employer's Name: _____

Employer's Address: _____ (Street) _____ (Town) _____ (State) _____ (Zip)

Insurance Plan Name: _____ Group # _____

Insurance Address: _____ (Street) _____ (Town) _____ (State) _____ (Zip)

Insurance Phone: ( ) _____

Is Patient covered by additional dental insurance? Yes ☐ No ☐ If Yes, an additional form should be completed.

CONSENT FOR TREATMENT, INSURANCE PAYMENT AUTHORIZATION AND FINANCIAL POLICY DISCLOSURE

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third-party or insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility. Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances. This office will help prepare insurance forms and assist in making collection from insurance companies: however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account. If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge a fee for appointment missed or canceled with less than 24 hours advance notice. This office reserves the right to charge interest of APR = 12% for overdue balances or a billing fee of seventy five cents. Inconsideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to the Doctor or his assignee at the time services are rendered or within 15 days of billing if credit is extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I agree to pay all costs of collection, including attorney's fees and expenses, incurred to collect any unpaid fees.

Signature _____ Date _____

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DENTAL HISTORY

Reason for Today's Visit: _____

Date of the Last Dental Visit: _____

Former Dentist's Name: _____

Address: _____
Street Town State Zip

Phone: ( ) _____

Do you have severe anxiety about dental treatment? Yes ☐ No ☐

Have you ever had an adverse reaction to dental Yes ☐ No ☐
treatment? If **Yes**, please explain: _____

HEALTH HISTORY

Physician's Name _____

Address: _____
Street Town State Zip

Phone: ( ) _____

Date of last physical exam: _____

Are you currently being treated by a physician? Yes ☐ No ☐

*If **Yes**, please explain:* _____

Have you been admitted to a hospital or had emergency care in the past two years? Yes ☐ No ☐

*If **Yes**, please explain:* _____

Are you currently taking any medications, including oral contraceptives or aspirin? Yes ☐ No ☐

*If **Yes**, please list:* _____

Have you had an allergic reaction? Yes ☐ No ☐

*If **Yes**, please list all allergies:* _____

Do you currently use tobacco? Yes ☐ No ☐ *If **Yes**, for how many years?* _____

*If **No**, have you used tobacco in the past?* Yes ☐ No ☐ *If **Yes**, for how many years?* _____ *When did you quit?* _____

Do you consume alcoholic beverages? Yes ☐ No ☐ *If **Yes**, how often?* _____

Do you have any history of the following diseases or conditions?

Anemia	☐	Fainting	☐	Liver Disease	☐
Anxiety / Depression	☐	Gastrointestinal Disorders	☐	Lyme Disease	☐
Arthritis	☐	Hearing Loss	☐	Migraines / Headaches	☐
Asthma / Hey Fever	☐	Heart Attack / Stroke	☐	Neurological Condition	☐
Autism	☐	Heart Disease	☐	Nutritional Deficiency	☐
Back Problems	☐	Hear Murmur	☐	Orthopedic Problems	☐
Bleeding Disorder	☐	Hepatitis: Type	☐	Rheumatic Fever	☐
Brain Injury	☐	Herpes	☐	Sickle Cell Trait or Disease	☐
Cancer: Type	☐	High Blood Pressure	☐	Syndrome: Type	☐
Cerebral Palsy	☐	High Cholesterol	☐	Scoliosis	☐
Cleft Lip / Palate	☐	HIV Infections (AIDS)	☐	Thyroid Condition	☐
Diabetes: Type	☐	Hypertension	☐	Transfusion of Blood	☐

Other conditions we should be aware of: _____

Women Only:

Are you Pregnant? Yes ☐ No ☐ Are you Nursing? Yes ☐ No ☐

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctors and his staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Patient's Name _____

Signature _____ Date _____

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PRIVACY POLICY

Established to protect the privacy of your health care and personal information. It is our policy to protect your privacy by complying with the HIPAA Privacy Rule.

The HIPAA Privacy Rule establishes a foundation of Federal protection for personal health information, carefully balanced to avoid creating unnecessary barriers to the delivery of quality health care. As such, the Rule generally prohibits a covered entity from using or disclosing protected health information unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities.

Ready access to treatment and efficient payment for health care, both of which require use and disclosure of protected health information, are essential to the effective operation of the health care system. In addition, certain health care operationsð such as administrative, financial, legal, and quality improvement activitiesð conducted by or for health care providers and health plans, are essential to support treatment and payment. Many individuals expect that their health information will be used and disclosed as necessary to treat them, bill for treatment, and, to some extent, operate the covered entityôs health care business. To avoid interfering with an individualôs access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities.

codes and practices in common use today. It is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information. The Privacy Ruleôs requirements for minimum necessary are designed to be sufficiently flexible to accommodate the various circumstances of any covered entity.

I hereby give permission to discuss my treatment with the following individuals:

☐ Mother ☐ Father ☐ Husband ☐ Wife

☐ Other_____

I have been informed of this policy and have been offered a written copy.

Patient's Name: _____

Signature _____ Date: _____

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FINANCIAL POLICY

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:
1. Cash
2. Check
3. MasterCard
4. Visa
5. Novus/Discover
6. Credit card authorization for recurring charges:
    a. Treatment exceeds $200
    b. Plan may not exceed 4 months

Patient with insurance: The **PATIENT** is responsible for the **ESTIMATED** non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A $15 fee is charged for nonpayment.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There may be a nominal charge for release or copies of records.

I, _____ , have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my deoendents is mine, due and payable at time services are rendered unless financial arrangements have been made. I further understand that a finance rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Signature _____ Date_____

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Heather Hinton
Telephone: 410-321-8480
Fax: 410-321-8482
E-Mail: sweettoothtowson@gmail.com
Address: 8600 Lasalle Road Ste 507.
Towson, MD 21286

I, _____ , do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force frim this time forward.

Signature_____ Date_____

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MISSED APPOINTMENT and LATE CANCELLATION POLICY

initial_____ **Missed Appointment Policy**

Our goal is to provide quality Dental care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments. A $25 per half hour fee will be assessed to those who no show, cancel less than 24 hrs or are more than 10 minutes late to their appointments

initial _____ **No Call, No Shows**

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. A no-show is when a patient misses an appointment without calling to notify us they will not be coming in for their appointed time.

initial _____ **Appointment Cancellation**

In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment. If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

initial _____ **Late to Appointment**

If you arrive more than 10 minutes late, we may need to reschedule your appointment. We schedule appointments to ensure we have time to complete the procedure with excellence, for proper disinfection of the room between patients. We do not schedule extra time to allot for late arrivals. It is also not fair to run into the time scheduled for the next patient who arrived on time. We understand there are extenuating circumstances like traffic and getting out of work late. If you know you are going to be late to your appointment, please call us immediately to let us know. It is possible we can make accommodations with advanced notice of tardiness.

initial _____ **How to Cancel Your Appointment**

If you need to cancel your appointment, please call us at 410-321-8480 between the hours of 9:00am-5:00pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible. You may also cancel your appointment by text message from the message you receive to confirm your appointment.

_____ _____

Signature Date