PATIENT TREATMENT RECORD

Patient Name: _____ Soc. Sec. No. _____

Address: _____ Birth date: _____

City: _____ State: _____ Zip: _____ Dental Plan? Yes____ No _____

Parent/Guardian: _____ Insurance Company: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email: _____ Referred by? _____

MEDICAL HEALTH HISTORY

Please check any of the following that apply to you:

- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (Please List):

_____
_____
_____
_____

Do you have an allergy to any of the following?

- ☐ Asprin
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Codeine
- ☐ Other: _____

What medications are you currently taking? _____

_____

Are you under physician's care? For what?

_____

Family Physician Name: _____

Phone Number: _____

For WOMEN Only:

- ☐ Birth Control Pills
- ☐ Breast Feeding
- ☐ Pregnant? If so, how far along? _____

DENTAL HEALTH HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete xrays _____/_____

Name of previous Dentist:

_____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

Do you smoke or use chewing tobacco? _____ If so, how much? _____ How long? _____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10?

Why did you leave your previous dentist? _____

_____

What is the most important thing to you about your dental visit today?

_____

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NEW PATIENT INFORMATION

Name (Print): _____

Category: General

1. *What quality of Dentistry do you want us to recommend?*
Choose ONE of the following:
__ A: Ideal, the best __ B: Average __ C: Just patch it

2. *What condition would you like your oral health to be?*
Choose ONE of the following:
__ A: Excellent __ B: Average __ C: Not a concern

3. *Should you need treatment, at what point should we address it?*
Choose ONE of the following:
__ A. When something isn't ideal. __ B: When something is worsening __ C: When my tooth hurts or breaks

4. *When considering treatment and your insurance coverage, our office should:*
Choose ONE of the following:
__ A: Treat only what insurance covers __ B: Do what's needed

Category: Medical History

5. *Do you feel fully rested upon rising in the morning?*
__ Yes __ No

6. *Do you suffer from daytime sleepiness?*
__ Yes __ No

7. *Have you been told by someone else that you snore loudly?*
__ Yes __ No

8. *Have you ever had an incident of acid reflux?*
__ Yes __ No

9. *If yes, how often are you aware of the reflux?*
Choose ONE of the following:
__ Often/ I take medication __ Occasionally/ I use OTC meds

10. *Have you been infected with the HIV Virus?*
__ Yes __ No

Category: Administrative

11. *Please provide your email address. (This will not be shared, nor will any spam be* sent.)

_____

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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 effect. This Notice takes effect January 1, 2003 and remains 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 suing the information listed at the end of this Notice.

USES OF DISCLOSURES OF HEALTH INFORMATION

We use and disclose heath 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 a 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 must 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 to 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 your 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: 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 be specify the alternative means or location, and provide a 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 by electronic mail (e-mail), you are entitled to receive this Notice in written form.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about the access to our health information or in response to a request made to amend or restrict the use or disclosure of your health information or to have us communicate with us 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 Service 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. If you want more information about our privacy practices or have any other questions or concerns, please call our office.

Contact Officer:	Thomas Fenlon, D.D.S.
Telephone:	410-442-2800
Address:	12800 Frederick Rd. West Friendship MD 21794

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Acknowledgment of Receipt of Notice of Privacy Practices

** You May Refuse To Sign This Acknowledgment **

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain writer acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgment

( ) Other (Please Specify)

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Dental Insurance Policy

Thank you for choosing our office for your dental care. We are excited that you have dental insurance, which will assist you in obtaining your dental care in our office.

If you choose, we will gladly assign payments for dental treatment from your insurance company directly to our office. If you choose to have assignment of benefits to our office, read the following:

1. We must have a valid credit card number on file for you and/or your family. Remaining balances will be charged to your card once all reasonable attempts have been made to collect from both you and your insurance company. Our office will contact you before any charges are made to your credit card.

2. You agree that the charges you incur here are your responsibility regardless of what your insurance company pays or does not pay towards your treatment.

3. You agree to pay your bill in full (via credit card on file) if your insurance company has not paid within 90 days. You understand that your insurance company may ask for additional information and we will provide this information upon request. If this happens, it is possible that payment will be delayed and not received within 90 days, in which case you agree to authorize us to charge your credit card for any outstanding balance. If for any reason there is an overpayment on your account, a refund check will be sent to the party who overpaid.

4. You agree that we are not responsible for knowing the various scenarios in which your insurance does not pay for services. Such scenarios include pre-existing conditions, waiting periods, x-rays which can only be paid on every so often, less costly alternatives, required pre-authorizations, etc.

5. Your insurance company may use these and other reasons to avoid paying your claim. We will try to provide you with as much information as possible; however, we will not be responsible for knowing the various intricacies of your particular insurance contract. You will need to be responsible for knowing your benefits and informing us of any changes.

6. If you do not wish to leave a credit card on file, we will require that you pay for treatment in full at time of service, no exceptions. We can then provide you with the required information so that you may submit for reimbursement from your insurance company. Another option you have is to use an outside financial agency. This type of agency works like a credit card. Once you are approved, the agency will pay the office in full and you will pay nothing to us at the time of treatment. You can then pay the agency on a monthly basis at your convenience. Also, you may submit to your insurance company for reimbursement and then use that to pay the financial agency.

Credit Card Authorization

I understand that the fees I incur at Howard County Family Dentistry are ultimately my responsibility regardless of whether or not my insurance covers my treatment for whatever reason. I authorize the staff of Howard County Family Dentistry to charge my credit card any balance that is outstanding after my insurance pays or after 90 days from the date of service whichever shall come first. I extend this same authorization for the account of my spouse and/or dependants.

Cardholder Name: _____ Patient(s) Name: _____

Master Card or Visa

Credit Card type: _____ Card #_____ Exp. Date: _____

Signature: _____ ***Rev. 07/13***

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Howard County Family Dentistry
Financial Policy

In an effort to help you to understand how our office operates, please take a moment to review our financial procedures. We believe that clearly defined financial arrangements are essential in avoiding needless misunderstandings. Just like most other businesses, we require payment on the day services are rendered. Each visit may be paid for with cash, check or credit card. (Visa or Master Card)

For our patients who carry dental insurance, please understand that your policy is a contract between you and your insurance carrier. This office has no contracts with any insurance company. We will fill out and submit your forms. Payment will also be accepted from your carrier. Keep in mind no insurance company pays 100% of all services. If your insurance only pays a percentage of any procedure, your portion of the payment is due at the time services are rendered. It is important that you, the patient, understand that some carriers take as long as 12 weeks before making a payment. We will do everything in our power to recover payment from the insurance company. However, after 90 days, if no payment has been received from your carrier, you are responsible for immediate payment to our office. Remember, the insurance policy is between you and your insurance company and does not relieve you of your financial responsibility to this office for services rendered. Hopefully, all transactions with your insurance company will go smoothly, but ultimately you are responsible for your bill.

For major restorative and re-constructive work, 1/2 payment of your estimated fee (after insurance coverage) is due at the beginning of treatment. The balance can be worked out with our office manager. Special financial arrangements can be made in advance of treatment.

A 5% administrative allowance will be made for all restorative work paid in advance with cash or check.

If you do not pay the entire NEW BALANCE within 90 days of the date of service a LATE PAYMENT CHARGE will be added to the account for the current monthly billing period. The LATE PAYMENT CHARGE for the month is 1.5% of the unpaid balance. In the case of default of payment, I promise to pay the LATE PAYMENT CHARGES on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Please know that we are reasonable and quite willing to work with you in meeting the financial obligations to our office.

Signature_____ Date_____

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In accordance with State Law HB230, which allows for the general supervision of treatment by a dental hygienist, I grant my consent for the designated treatment as outlined by my dentist, **Thomas J. Fenlon, D.D.S**. Under general supervision, the doctor prescribed hygiene treatment may be accomplished with or without my dentist on the premises.

Patient: _____
Please print

Signature: _____
Patient or legal guardian

Date: _____