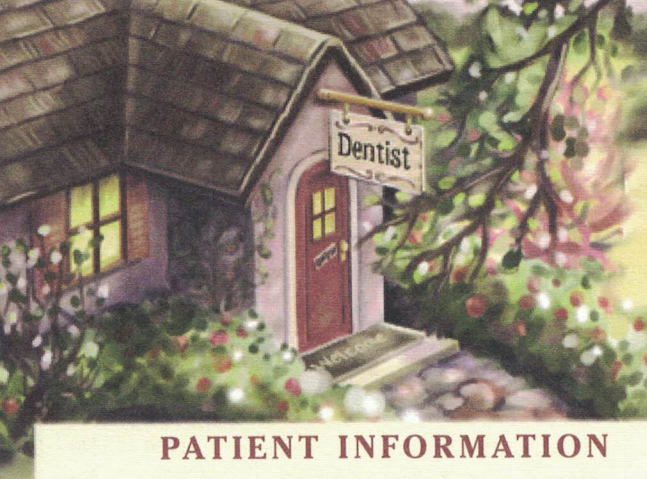

Dental Registration Form

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
		Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____)_____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____)_____ Work Phone (_____)_____

UPDATE (To be filled in at future appointment)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

REGARDING YOUR INSURANCE: PLEASE READ BEFORE SIGNING

Patient Name:_____ Date of Birth:_____

Insurance Assignment:

If I have insurance, a claim for reimbursement for services rendered will be submitted once, based on information that I provide to Georgetown Dental Aesthetic on the date of service. I understand that I am responsible for payment in full for all non-covered services rendered; co-insurance filings, deductibles, co-payments and any difference between the submitted charges and the insurance payment after any adjustments have been applied to my account.

In the case of primary and secondary insurance, I understand that my primary insurance will be the only insurance used to file my dental claims in this office. As regards my secondary insurance, I will be responsible for filing my own claim to receive payment for services rendered to me. The payment will be sent to me from my secondary insurance for the services renders to me and I will be responsible for paying the remainder balance on my account.

I understand that the practice will not submit claims more than once. If payment has not been made after 60days from the date of service, whether due to incomplete or incorrect information that I provide or due to a delay of the insurance company, all charges are my responsibility and will be effective immediately. It will then be my responsibility to deal with my insurance company. I also understand that if I allow my balance to be unpaid for more than 60 days, there will be a finance charge of 2% added monthly. After 180 days, my balance will be submitted to the attorney for collections.

Self Pay:

If I currently do not have dental insurance, I am responsible to pay all charges for services provided to me on the same day of service.

By signing below, I signify that I have read and fully understand all of the above statements.

Signature of person responsible of payment:_____

Please Print your name here :_____

Today's Date :_____

HIPAA Notice of Privacy Practices

Revised 10/21/2019

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.

1. OUR RECORD OF YOUR HEALTH INFORMATION

Each time you receive services, a record of your visit is made. This record may describe your condition, diagnoses, treatments and/or a plan for future care. Health information such as test results, medications and information obtained by your provider will be recorded.

2. WHEN WE NEED YOUR WRITTEN PERMISSION TO USE AND DISCLOSE YOUR HEALTH INFORMATION

We must obtain your written authorization for uses and disclosures of your health information, except as described below in this Notice. We must, for example, obtain your written authorization for certain uses and disclosures involving the sale of your health information or for any use or disclosure of your health information for marketing purposes.

3. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS WITHOUT YOUR WRITTEN AUTHORIZATION

We may use or disclose your health information without your written authorization for the purposes of treatment, payment and health care operations. Examples of such uses are as follows:

Treatment – to provide, manage and coordinate your oral health care. Your treatment could also involve disclosing information to other providers such as a referring health care provider or other health care providers involved in your care for the purpose of providing you excellent, coordinated care; sending you appointment reminders; contacting you about your care and treatment choices, or telling you about services that may interest you.

Payment – to obtain payment and determine health insurance eligibility. We may tell your health plan about treatment or services that may require its prior approval.

Health Care Operations – to assess the quality of care we provide, to improve our services, to train our staff, and to manage our operations and services.

4. WE MAY BE PERMITTED OR REQUIRED TO USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

We are also permitted or required to use your health information or disclose your health information to others without your written authorization as follows:

- Within Georgetown Dental Aesthetic and to business associates as needed for assistance with our operations, subject to protections for your health information.

- Incidental to a use or disclosure otherwise permitted or required.
- For federal and state health oversight activities such as fraud investigations.
- In judicial or administrative proceedings, pursuant to, for example, a subpoena, court order, or other lawful process.
- To law enforcement officials in limited circumstances.
- To the Secretary of Health and Human Services, if it conducts an investigation to determine our compliance with HIPAA.
- Unless you object, to family and friends involved in your care if, in our professional judgment, it is in your interest for us to disclose information directly relevant to that person's involvement with your care.
- Unless you object, to a family member, personal representative, or person responsible for your care in order to notify them of your location, general condition.
- Otherwise, as required or permitted by HIPAA and all other applicable laws.

5. YOUR RIGHT TO INSPECT AND RECEIVE COPIES OF YOUR HEALTH INFORMATION AND TO REQUEST THAT WE RELEASE YOUR HEALTH INFORMATION TO OTHERS.

You have the right to inspect and receive copies of your health information in our health records and to request that we release a copy of this health information to others. A modest fee may be charged. Please speak to your dentist if you have questions about making a request. Your request may be denied in whole or in part when the following circumstances exist:

- Information compiled in anticipation of or use in a civil, criminal or administrative action or proceeding.
- Health information that we obtained from someone other than a health care provider under a promise of confidentiality if the access requested would be reasonably likely to reveal the source of the information.

We retain our health records for 7 years from the date of final treatment.

6. YOUR ADDITIONAL RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Receive a copy of their Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your health record.
- Request, in writing, that we restrict how we use or disclose your health information. For example, you may request us not to disclose health information to a health plan for payment pertaining to items or services for which we have been paid in full by you or a person other than the health plan.
- Revoke, in writing, any authorization you have given to disclose your information; but we won't be able to take back information we have already.
- Request a confidential and/or alternate modes of communication.
- Request in writing an amendment to the information in your health record.
- Request in writing and receive an accounting of the disclosures we have made of your health information, except for disclosures to you, disclosures you authorized, and disclosures that are permitted or required without your authorization.
- Make a complaint about our privacy practices.
- In the event of a breach of your unsecured protected health information, to receive notification of the breach.

- 7. OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your health information.
- Provide you this Notice of your rights and our duties and our privacy practices.
- Abide by the terms of our Notice of Privacy Practices as currently in effect.
- Notify you following a breach of your unsecured protected health information.
- Notify you if we are unable to continue to comply with your restriction request.

We reserve the right to change our privacy practices and this Notice and to make the new practices effective for all your health information including information we already have about you. The revised Notice will be posted on our website and made available at our treatment site.

8. TO EXERCISE YOUR RIGHTS OR FILE A COMPLAINT

If you have questions about this Notice, would like to exercise your rights, or wish to file a formal complaint regarding the privacy of your health information, please contact:

HHS Headquarters (202)690-7000

U.S. Department of Health & Human Services

The mailing address is:

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

If you believe your privacy rights have been violated, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized or subject to retaliation for filing a complaint.

GEORGETOWN DENTAL AESTHETIC

2440 M Street, N.W., Suite #608

Washington, D.C. 20037

(202)822-3785

Patient Acknowledgement of Notice of Privacy Practices

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care options.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description or uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  The right to receive confidential communications of protected health information.
  The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):_____

UNDERSTANDING YOUR INSURANCE COVERAGE

Your Insurance policy is an agreement between you and your insurance company or your employer and the insurance company. The policy lists a package of dental benefits such as evaluations, x-rays, cleanings and other treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services". Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered dental services that you received. Keep in mind that a **dental necessity** is something that your dentist has decided is necessary. A **dental benefit** is something that your insurance has agreed to cover based on your plan with them. In some cases, your dentist may decide that you need dental care that is not covered by your insurance policy. Insurance companies determine what services they will cover. Even if your insurance company tells you that a service is covered, it is just an estimate until they receive the actual claim and payment will still be collected based on the coverage information provided to us. These choices are based on their understanding of the kinds of dental care that most patients need. Your insurance company's choices may mean that the services that you need isn't covered by your policy.

There are so many different insurance plans that it is not possible for your dentist to know the specific details of each plan. By understanding dental treatment and insurance coverage, you can help your dentist and yourself to maximize your benefits. This will also help your dentist recommend the dental treatment covered in your plan based on the estimated coverage.

Below are some things that may help you when trying to understand your insurance policy:

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service. Some kinds of care may require a predetermination for your insurance company before your dentist can provide them.

- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.

- Remember that your insurance company, <u>not your dentist</u>, makes decisions about what will be paid for and what will not.

- Remember that your doctor, <u>not your insurance company</u>, makes dental decisions and recommendations about what will benefit your treatment and health status.

- Note that if the dentist participates with your insurance company and they do not pay for one of the services, the doctor is allowed to bill you the full amount for that service.

Most of the things that your dentist recommends in your treatment may be covered by your plan, but some will not. When you have treatment that isn't covered, your insurance company won't pay the bill. This is often called "denying the claim". You can still obtain the treatment your dentist recommended, but you will have to pay for all of it yourself. If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan handbook. Also, ask your dentist for his or her opinion.

If your dentist thinks that it's right to make an appeal, he or she may be able to help you through the process. If you decide to appeal after finding out how much the insurance has paid for your services and there is a balance left, you must still pay the balance due to your dentist regardless of your decision to appeal the insurance denial or not.

By Signing below, you signify that you have read and fully understand all of the above.

Today's Date: _____

Patient Name: _____

Patient Signature: _____