

Patient Information

**Please save this form on computer first and fill it out using ADOBE.
Email the completed form to info@baltimorefamilydental.com**

Date _____ Name _____ Sex M ___ F ___
Last, First, MI

Address _____ City _____ State _____ Zip _____

SSN _____ Birthdate _____ Email _____

Patient Employer _____ Occupation _____

Employer Address _____ Employer Phone _____

Please tell us how you heard about Baltimore Family Dental:

Mailer ___ Newspaper ___ Internet ___ Referred By _____ Other _____

Phone Numbers

Home _____ Cell Phone _____ Work _____

Appointment Reminder Preference: Cell Phone ___ Text ___ Home Phone ___ Work Phone ___ Email ___

Emergency Contact Name _____ Relationship _____ Phone _____

Insurance Information

Do you have Dental Insurance? Yes ___ No ___ Do you have secondary Dental Insurance? Yes ___ No ___

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self ___ Spouse ___ Child ___ Other ___	Relationship to Subscriber	Self ___ Spouse ___ Child ___ Other ___
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

***Please present Insurance Card to the receptionist to be photocopied ***

Medical History

Baltimore Family Dental takes your oral health very seriously, but before we start your treatment, we need some brief information on your medical history. Your medical history may affect dental treatment. **All information is confidential.**

Have you been under the care of a Medical Doctor during the past two years? Yes ___ No ___

If yes, for what? _____

Physician's Name _____ Last visit to Physician _____

Are you currently taking any medications, drugs or pills? Yes ___ No ___

If yes, please list name and dosage: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphotanes?

Yes ___ No ___ If yes, for how long? _____

Are you allergic to any of the following? Aspirin ___ Penicillin ___ Codeine ___ Local Anesthetics ___

Acrylic ___ Metal ___ Latex ___ Sulfa drugs ___ Other (if yes, please explain) _____

Do you have a history of?	Y		Yes		Yes		Yes
Rheumatic Fever		Asthma		Thyroid Disease		Alcoholism	
Heart Murmur		Allergies or Hives		Epilepsy or Seizures		Psychiatric Treatment	
Mitral Valve Prolapse		Anemia		Fainting or Dizzy Spells		Mouth sores/growths	
Diabetes		Aspirin/Anticoagulant Therapy		Ulcers or Stomach Problems		Teeth Grinding/Clenching	
Pace Maker/Heart Surgery		Venereal Disease		Arthritis		Pain in your jaw (TMJ)	
High Blood Pressure		HIV Positive/AIDS		Latex Allergy		Any type of implant	
Low Blood Pressure		Blood Transfusion		Sinus Problems		Any type of transplant	
Heart Problem ()		Excessive Bleeding		Cancer (Type:)		Any Artificial Hip, Knee or other Joint	
Stroke		Hepatitis (Type:)		Chemotherapy		Other Disease or Illness:	
Lung Disease		Liver Disease		Radiation Treatment			
Breathing Problems		Kidney Disease		Use of Tobacco Products			
Tuberculosis (TB)		Dialysis		Drug Addiction			

Dental History

What is the purpose of your visit today? _____

Are you currently in pain? Yes___ No___ Do you require antibiotics before dental treatment? Yes___ No___

Have you experienced problems associated with any previous dental work? Yes___ No___

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes___ No___

Your current dental health is: Good___ Fair___ Poor___

Do you floss daily? Yes___ No___ Brush daily? Yes___ No___

Type of bristles on your toothbrush? Hard___ Medium___ Soft___

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes___ No___ If yes, what? _____

Would you like fresher breath? Yes___ No___ Whiter Teeth? Yes___ No___

Do your gums ever bleed? Yes___ No___

Have you ever had periodontal disease? Yes___ No___

Do you have mobility in your teeth? Yes___ No___

Are your teeth sensitive to heat, cold or anything else? Yes___ No___

Do you still have wisdom teeth? Yes___ No___

Previous/Present Dentist_____ Last Visit Date_____

Are you happy with the way your smile looks? Yes___ No___

If not, what would you change? _____

Women

Are you pregnant or planning pregnancy? Yes___ No___ Are you a nursing mother? Yes___ No___

If yes, due date_____ Are you taking birth control pills? Yes___ No___

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Baltimore Family Dental 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's Signature_____ Date_____

Dr's Signature/Medical History Review_____ Date_____

HIPAA POLICY

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this might include coordinating medication with your medical doctor, implant services, lab services etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this might be filing a claim with your insurance company.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.

- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

The following patient hereby acknowledges the receipt of this HIPAA Policy.

Patient Name _____ Relationship to Patient

Signature: _____ Date _____

For more information about HIPAA or to file a complaint, please contact:

US Dept of Health & Human Services Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

Or feel free to contact us if you have any questions or for additional information.