DIRECTIONS TO:

Modern Dental Center
9690 Deereco Rd, Suite 120
Timonium, MD 21093
410-560-2616

<u>From Baltimore City or Towson Area</u>

I-83 North:

Take exit 17 for Padonia Road. Stay in the right lane as you get off the exit ramp. The first light you come to will be for Deereco Road. Make a right onto Deereco Rd. Our building will be the third driveway on the left. It is a tall, mirrored building.

<u>From PA</u>

I-83 South:

Take exit 17 for Padonia Road. You will come to a light once you get off the exit ramp. Make a left at the light onto Padonia Road. The next light you will come to is Deereco Road. Make a right onto Deereco Rd. Our building will be the third driveway on the left. It is a tall, mirrored building.

<u>Heading North on York Road:</u>

You will come to a light for Padonia Road, make a left onto Padonia Road. The second light you come to will be for Deereco Road. Make a left onto Deereco Rd. Our building will be the third driveway on the left. It is a tall, mirrored building.

<u>Heading South on York Road:</u>

Merge right onto Padonia Road. The second light you come to will be for Deereco Road. Make a left onto Deereco Rd. Our building will be the third driveway on the left. It is a tall, mirrored building.

Modern Dental Center

NOTICE OF PRIVACY PRACTICES

The Privacy of Your Healthcare is Important to Us.
Please Read This Notice Carefully. It describes How Your Health Information May Be Used and Disclosed, and How You Can Get Access to this Information.

Legal Requirements:
We are required by federal and state law to maintain the privacy of your healthcare information. We are also required to notify you of this Notice. This Notice will describe our privacy practices, our legal duties, and your rights concerning your health information. Although we have always maintained health privacy practices in the office, we are now required to notify patients of our policy. This policy will take effect April 14, 2003 and will remain in effect until replaced.

This office reserves the right to change any or all of our privacy practices as required or provided by law. Upon any significant changes to this policy, we will change this Notice and make a new Notice available upon request.

You may request a copy of this Notice at any time. For more information or for additional copies of this Notice, please contact us in writing as described later in this Notice.

Uses and Disclosures of Health Information:
We will use and disclose your health information for treatment, payment, and healthcare operations as described below.

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 or disclose you 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 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's Rights section of this Notice. We may disclose your information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

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 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 consent.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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 institutions or lawful enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose health information to provide you with appointment reminders (such as voice mail 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 practically do so. (You must make a request in writing to obtain access to health information. You may obtain a form to request access by notifying the office. If you request copies, we will charge you a reasonable fee for staff time to locate and copy your health information, and postage if you want copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a form to fill out requesting copies of health information).

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 that 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, reasonable, 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 this 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 that 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.

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Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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.

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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 your health information for any reason except those described in this Notice.

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

MODERN DENTAL CENTER will use your health related information for the purposes of providing you with dental treatment, obtaining payment of services rendered and/or general healthcare operations. Your health-related information will be submitted through the following mechanisms: US Postal Service, Fax submissions, Internet submissions, voice mail and/or personal communications. The most common entities that will receive this information are: other providers, lab facilities, insurance companies, and pharmacies. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have the right to review this statement prior to receiving healthcare and prior to signing this consent.. The terms of our Notice of Privacy Practices may change at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment and/or healthcare operations. We are not required to agree with your requested restriction. In the event we do agree with your requested restrictions, we will adhere to these restrictions. If we do not agree with your request, we will discontinue treatment.

I have received a copy of the practice's Notice of Privacy Practices to review _____ (Initial)

I understand that I may revoke, at any time, this consent. This revocation will not effect previous actions, prior to the revocation. ______ (Initial)

I consent to the above noted terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or healthcare operation. I understand that this consent will remain in effect until I revoke it, in writing.

Patient Name (Print): ____________________________ Date: ______________________

Patient's Signature (or Patient's Representative): ________________________________

Witness: ____________________________________

Email:

Today's Date____________________

Patient Information

Name____ Nickname____________________
First MI Last

Address____
Street City State Zip

Home Phone______________ Work Phone________________ Cell Phone__________________

Employer/Occupation ____________________________ Birth Date ______________ M F
Month Date Year Sex

Employer Address ______________________________ SSN______________________

In Case of Emergency, Contact:__________________________ Phone ____________________

Whom May We Thank For Referring You To Our Office? ______________________________

Account Responsibility

If person responsible for this account is different then patient, please complete this section:

Name____ Relation____________________
First MI Last

Address____
Street City State Zip

Home Phone______________ Work Phone________________ Cell Phone__________________

Employer/Occupation ____________________________ Birth Date ______________ M F
Month Date Year Sex

Employer Address ______________________________ SSN______________________

Primary Dental Insurance

Do you have dental insurance? Y N (If no skip this section)

Employee Name ________________________________ Birth Date________________

Employer____________________________________ SSN ____________________

Employer Address ______________________________ Relation ________________

Insurance Company______________________________ Group # ________________

Insurance Address ______________________________ Phone __________________

Secondary Dental Insurance (if applicable)

Employee Name ________________________________ Birth Date ________________

Employer____________________________________ SSN ____________________

Employer Address ______________________________ Relation ________________

Insurance Company______________________________ Group # ________________

Insurance Address ______________________________ Phone __________________

Dental History

What is the reason for this appointment? ______________________________

Are there any specific dental problems we should be aware of? ______________________

Do your gums bleed easily when brushing or flossing? ☐ Yes ☐ No How often do you brush? __________

Do you suffer from chronic bad breath or bad taste? ☐ Yes ☐ No How often do you floss? __________

Do you have any jaw joint or cracking pain? ☐ Yes ☐ No

When was your last dental visit? ____________________ Name of previous dentist __________

When was your last dental cleaning? ____________________ Last dental xrays? __________

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Patient Treatment Consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon Diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) an mutually agreed upon me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorize this Practice to submit insurance claims forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE" . I authorize my dentist to release treatment records/xrays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.
- I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1 ½% per month.

Patient/Parent/Guardian Signature______________________________ Date________________

PLEASE COMPLETE REVERSE SIDE!!!

Have you ever had any of the following? Check those that apply:

□Aids/HIV	□Excessive Bleeding	□Kidney Disease	□Stomach Problems
□Anemia	□Fainting	□Liver Disease	□Stroke
□Arthritis	□Glaucoma	□Lung/Breathing Problems	□Thyroid Problems
□Artificial Joints*	□Growths	□Mental Disorders	□Tuberculosis
□Asthma	□Hay Fever	□Nervous Disorders	□Tumors
□Bleeding Disease	□Head Injuries	□Pacemaker	□Ulcers
□Blood Disease	□Heart Disease	□Pregnancy	□Venereal Disease
□Bronchitis	□Heart Murmur*	Due Date ________	**Allergic to:**
□Cancer/Tumors	□Heart Valve Defect*	□Radiation/Chemotherapy	□Aspirin
□Diabetes	□Heart Valve Replacement*	□Respiratory Problems	□Codeine
□Dizziness	□Hemophilia	□Rheumatic Fever*	□Latex
□Do You Smoke?	□ Hepatitis	□Rheumatism	□Novacaine
□Epilepsy/Seizures	□ High Blood Pressure	□ Sexually Transmitted	□Penicillin
□Emphysema	□Jaundice	□Sinus Problems	□Sulfa
□ **NONE**	□ **NONE**	□ **NONE**	□Other ___________
			□ **NONE**

*Do you need to take antibiotic pre-medication prior to dental appointments? □ Yes □ No
If yes, name of antibiotic? ________________

- □ Are you presently taking any medications, pills or tonics? □ Yes □ No
  If yes, please explain: ____________________
- □ Have you ever had any complications following dental treatment? □ Yes □ No
  If yes, please explain: ____________________
- □ Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
  If yes, please explain: ____________________
- □ Are you under a physician care now? □ Yes □ No
  If yes, please explain: ____________________
  Name of Physcian ____________________ Phone ____________
- □ Do you have any health problems, not listed above, that need further clarification? □ Yes □ No
  If yes, please explain ____________________

I certify that the above information is complete and is accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or meds

________ Date | ________________ Patient/Guardian Signature | ________________ Dr/Hygienist Signature

Yearly Review of Patient Medical Record

No Change	Change	List:	Date	Patient/Guardian Signature	Dr/Hygienist Signature
□	□				
□	□				
□	□				
□	□				
□	□				

Below for Office Use Only

Initial Review of Patient Medical History
Medical Alert Recommended: □ Yes □ No
Premedication Recommended: □ Yes □ No
RX: ____________________

____

Interviewer Notes:
____
____

PLEASE COMPLETE REVERSE SIDE!!!

Email:

Today's Date ____________

Patient Information

Name ____________ (First, MI, Last) Nickname ____________

Address ____________ (Street, City, State, Zip)

Home Phone ________ Work Phone ________ Cell Phone ________

Employer/Occupation ____________ Birth Date ________ (Month Date Year) M F (Sex)

Employer Address ____________ SSN ________

In Case of Emergency, Contact: ____________ Phone ________

Whom May We Thank For Referring You To Our Office? ____________

Account Responsibility

If person responsible for this account is different then patient, please complete this section:

Name ____________ (First, MI, Last) Relation ________

Address ____________ (Street, City, State, Zip)

Home Phone ________ Work Phone ________ Cell Phone ________

Employer/Occupation ____________ Birth Date ________ (Month Date Year) M F (Sex)

Employer Address ____________ SSN ________

Primary Dental Insurance

Do you have dental insurance? Y N (If no skip this section)

Employee Name ____________ Birth Date ________

Employer ____________ SSN ________

Employer Address ____________ Relation ________

Insurance Company ____________ Group # ________

Insurance Address ____________ Phone ________

Secondary Dental Insurance (if applicable)

Employee Name ____________ Birth Date ________

Employer ____________ SSN ________

Employer Address ____________ Relation ________

Insurance Company ____________ Group # ________

Insurance Address ____________ Phone ________

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Do you suffer from chronic bad breath or bad taste? ☐ Yes ☐ No How often do you floss? ________

Do you have any jaw joint or cracking pain? ☐ Yes ☐ No

When was your last dental visit? ________ Name of previous dentist ________

When was your last dental cleaning? ________ Last dental xrays? ________

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorize this Practice to submit insurance claims forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my dentist to release treatment records/xrays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.
- I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1 ½% per month.

Patient/Parent/Guardian Signature ____________ Date ________

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