

Columbia Gateway Dentistry

7226 Lee Deforest Drive, Suite 208
Columbia, MD 21046
(410) 872-0103

Patient Information

Patient name: _____ Date: _____
Last First MI Gender: male female
Social Security #: _____ Birth date : _____ Family status: married single
Phone (home): _____ (work): _____ (cell): _____
Email: _____ Occupation: _____
Address: _____
Street City State Zip code

Health Information

Date of Last dental visit: _____ Reason for this visit: _____

<input type="checkbox"/> AIDS	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver disease	Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Mental disorders	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pacemaker	If so, how many weeks: _____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation treatment	Other Medical Conditions:
<input type="checkbox"/> Latex	<input type="checkbox"/> Growths	<input type="checkbox"/> Respiratory problems	_____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Rheumatism	List medications:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Sinus problems	
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach problems	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Blood disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> HIV	<input type="checkbox"/> Tumors	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Venereal disease	_____

- 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 now under the care of a physician? yes no
If yes, please explain: _____

Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? yes no
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date

Signature of Dentist Date

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Responsible Party Information

Only required if the person responsible for payment is different from the patient:

Name: _____ Single: _____ Married: _____ Divorced: _____
Social security #: _____ Birth date: _____
Employer name: _____ Occupation: _____
Address: _____
Street City State Zip code
Phone (home): _____ (work): _____ (Cell): _____

Insurance Information

Primary

Name of insured: _____ Is insured a patient? yes no
Last First MI
Insured's Birthdate: _____ SS #: _____
Address: _____
Street City State Zip code
Insured's Employer name: _____
Patient's relationship to insured: self spouse child other _____
Insurance Plan Name: _____ Group Name: _____
Insurance ID#: _____ Group No.: _____

Secondary

Name of insured: _____ Is insured a patient? yes no
Last First MI
Insured's Birthdate: _____ SS #: _____
Address: _____
Street City State Zip code
Insured's Employer name: _____
Patient's relationship to insured: self spouse child other _____
Insurance Plan Name: _____ Group Name: _____
Insurance ID#: _____ Group No.: _____

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 such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by 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 authorizes the Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.

Signature of Patient/Parent/Guardian _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Health Insurance Portability Accountability Act (HIPAA), 1996

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

PATIENT/GUARDIAN GIVING CONSENT

Name: _____

TO THE PATIENT/GUARDIAN – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Columbia Gateway Dentistry

(410) 872-0103

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCAION OF CONSENT

I, _____, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____

Date: _____

Financial Policy

Thank you for choosing Columbia Gateway Dentistry to serve your dental needs. We strive to provide the highest quality treatment at a reasonable cost to you. The following is a statement of our financial policy. Please read this document very carefully and sign below. If you have any questions or concerns about our Financial Policy, a member of our qualified staff will be happy to discuss your concerns with you. We have listed our payment options below for your convenience:

- Cash
- VISA, MasterCard, Discover and American Express
- Personal checks – proper identification is required

We cooperate fully with our patients who are covered by insurance plans. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. We expect insured patients to read their policies carefully. It is very important that you are familiar with your dental insurance plan benefits and limitations. We will accept assignment of benefits provided the necessary documentation has been provided. We do require that you pay your deductible and/or estimated co-pay at the time of service. If your insurance company has not paid your account in full within 45 days of treatment or denies your claim for ANY reason, you are responsible for the total balance.

- All prosthetic services **must be paid in full on or before completion.**
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
- I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- If my account is turned over for collection, I agree to pay any reasonable collection fees (25% is deemed reasonable)
- If suit is filed, I agree to pay reasonable attorney fees (33.3% is deemed reasonable), court costs, and other expenses incurred as a result of said collection. The undersigned agrees that should suit be filed, the venue (location of suit) shall be Howard County, Maryland, venue in any other counties being waived hereby.
- We consider the parent or guardian who brings the child to our office for treatment responsible party for payment of the child's account. If someone else is legally responsible for the child's account, it remains the responsibility of the parent or guardian bringing the child in for treatment to seek reimbursement for payment made to our office. We will be happy to assist you by providing you with a copy of the charges and payments made at each visit.
- **I understand that there will be a \$60.00 per hour missed appointment fee for any canceled appointment with less than 48 hour notice.**
- A **\$15.00** fee will be assessed for the duplication of records/x-rays.
- A **\$37.00** fee will be added to your account for returned checks.
- **If your insurance pays less than estimated, you will be billed any balance due regardless of any treatment plan estimate presented.**
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form

I have read and agree to the terms in this Office Financial Policy.

Signature of Patient/Parent/Guardian

Date

Printed name of patient