TIME 01:58 PM

DATE 5/6/2020

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address. Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Primary Medical History Form

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Do you use controlled substances?	Yes No	If yes	
Other?		If yes	

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

Northwest Dental
4821 Butler Road, Suite 2B
Glyndon, MD 21071
410-833-6200

FINANCIAL POLICY

We appreciate the opportunity to provide dental care to you and your family. We offer the following clarifications regarding our financial and insurance policies. Our office strives to maximize your insurance benefits and make any balance easily affordable. Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire.

Please note, because the insurance policy is an agreement between you and your insurance company, we expect all patients or their guardian to be fully responsible for knowledge of your insurance benefits, as well as fully responsible for all charges regardless of insurance overage. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment..

Payment is due at the time services are rendered unless prior arrangements have been made. We accept cash, checks and credit cards. Checks that are returned due to insufficient funds will be assessed a $25.00 fee to cover processing fees.

We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Often, financial misunderstandings can be managed with a phone call.

We require a minimum of 24 hours notice for cancellations. Failure to give a 24 hour notice will result in a fee up to $100.00 for each occurrence. Families with multiple appointments on the same day will be charged for each appointment on that day that is missed. Appointments that are longer than one hour may be charged an additional fee. Additional appointments will not be made until this fee has been paid.

I have read and understand the above information regarding Northwest Dental financial policy.

Patient Name: _____

_____ _____

Signature of Patient or Responsible Party Date

NOTICE OF PRIVACY PRACTICES

Northwest Dental Inc.
4821 Butler Road
Suite 2 B
Glyndon, MD 21071
410-833-6200

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.

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 that of 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 bottom of this notice. We will charge you a reasonable cost-based fee for expense such as copies and staff time. You may also request access by sending us a letter to the address at the top of this notice. If you request copies, we will charge $0.50 for each page, $2.00 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 information in that format.

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 6 years, but not before April 14, 2003. If you request this accounting more than once in a 2 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 restrictions on our use or disclosure of your health information. We are not to agree to these additional restrictions, however if we do, we will abide by our agreement (Except in an emergency).

Alternative Communications: 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 the request in writing). Your request must specify the alternative means or location, and provide a satisfactory explanation how payments will be handled under the alternative means or locations you requested.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

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 practitioners and provider performance, conducting training programs, accreditations, 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 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 or disclose your health information for any reason except those described in this notice.

To Your Friends and Family: We must disclose your health information to you, as described in the "Patient's 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, by only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification (Including identifying or locating) a family member, your personal representative, or another person responsible for your care, your location, your general condition, or death. However if you are present, then prior to use or disclosure of your location, your general condition, or death. If you are present, then prior to 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 bases 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 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 authorization.

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

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, 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a Correctional Institution or law enforcement officials 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, texts, or letters).

NOTICE OF PRIVACY PRACTICES

Northwest Dental Inc.
4821 Butler Road, Suite 2B
Glyndon, MD. 21071
410-833-6200

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.

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 practice, our legal duties, and your right concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain 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 changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we create or received before we made the changes. Before we make a significant change in our privacy practice, we will change this Notice and make the new Notice available upon request.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and agreed to Northwest Dental's Notice of Privacy Practices

Patient Name :_____(PRINT)

Patient Signature: _____ Date: _____

CANCELLATION POLICY

Northwest Dental requires a 24 hour notification of cancellation of your appointment. If your appointment is on Monday, you are required to call the previous Friday. Failure to give a 24 hour notice will result in a fee up to $100.00 for each occurrence. Families with multiple appointments on the same day will be charged for each appointment on that day that is missed. Appointments that are longer than 1 hour in time may be charged an additional fee. Additional appointments will not be made until this fee has been paid.

Patient Name: _____ (PRINT)

Patient Signature: _____ Date: _____

INSURANCE POLICY

Northwest Dental submits to all PPO insurance plans as a courtesy. Effective May 5, 2011, we will no longer submit claims that are 6 months or older. Patient will be responsible for all fees that have not been paid when the claim has reached 6 months from initial submission date.

Patient Name: _____ (PRINT)

Patient Signature: _____ Date: _____

Northwest Dental

Today's Date_____

Due to the coronavirus outbreak, we are screening all patients for risk factors. Please answer the following questions:

1)Do you have a **fever?** Yes____No_____

2)Do you have any **symptoms of respiratory illness**(e.g. cough, shortness of breath, difficulty breathing)? Yes_____No_____

3) Have you traveled outside of the Mid_Atlantic region or returned from a cruise within the last 14 days? Yes____No_____

4) Have you been in close contact with a person confirmed to have or possibly could have COVID-19? Yes____No_____