ADVANCE DENTAL CLINIC

700 GEIPE RD. SUITE 200
CATONSVILLE, MD 21228
(443) 251-5580

Patient's name_____ **Birth date**_____ **Sex: M F**
Address_____ **Apt#**_____
City_____ **State**_____ **ZIP Code:**_____
Soc. Security# _____ **Home phone**_____ **Work phone:**_____
Employer's name_____ **Occupation**_____
Cell#_____ **e-mail:** _____

Is patient covered by primary dental insurance? Yes No

Insurance Co _____ **Employer's Name** _____
Employee's name _____ **Birth date** _____ **Sex: M F**
SS# or subscriber number(shown on card) _____ **Group#** _____
Insurance company's phone # _____
Address_____
Relationship to patient: ( ) self ( ) spouse ( ) parent/guardian

Medical History

Do you have or have you ever been treated for:

	YES	NO		YES	NO		YES	NO
Any heart problems			Sickle-cell trait			Liver problem or dysfunction		
Heart attack			Blood transfusion			Adrenal or pituitary problem		
Angina			Sexual transmitted disease			Hepatitis or jaundice		
Bypass			Other infectious disease			Kidney problem/ dysfunction		
Pacemaker			Chemotherapy/radiation			Stomach trouble/ulcer		
Stroke			Are you pregnant?			Alcoholism		
High blood pressure			Other growths			Drug abuse		
Low blood pressure			Cancer or tumor			Nervous or mental disorder		
Do you need to pre-med			HIV/AIDS			Epilepsy or seizures		
Heart murmur			Do you smoke?			Thyroid problems		
Mitral-valve prolapse			Lung/breathing problems			Do you have osteoporosis?		
Heart-valve defect			Asthma			If taking meds, What?		
Heart-valve replacement**			Bronchitis					
Rheumatic fever**			Emphysema			Allergy to penicillin		
Artificial joint**			Tuberculosis			Reaction to local anesthesia		
Bleeding disorder			Sinus trouble			Allergy to erythromycin		
Anemia			Diabetes			Other allergies		
Hemophilia			Difficulty healing			List:		

)o you have any health problems not noted above? ( )Yes ( )No
Vhat? _____
re you being treated by a physician? _____ Why? _____
hysician's name and phone number:_____
re you taking any medications or pills? _____ If yes, please list below.
)rug: _____ purpose: _____
)rug: _____ purpose: _____
)rug: _____ purpose: _____
mergency contact person (s) : _____

ignature(self or patient or guardian) _____ **Date**_____

)entist's Signature_____ **Date**_____

Rev.5/09

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700 Geipe Rd. Suite 200
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Ph : 443-251-5580
Email: info@advancesmiles.com

Payment is due on the day professional services are rendered.

We make every effort to assist patients who have insurance in submitting claims. The estimated co-payment is due in full at each appointment.

When payment is received from your carrier, you will receive a statement for any outstanding balance or be reimbursed immediately for any overpayment. "After insurance" balance is due in full within 10 days of billing to avoid interest charges.

Unpaid claims more than 30 days are the responsibility of the patient to follow through. If more than 45 days have passed, payment in full is required. We will continue to assist you in getting reimbursed by your carrier.

In the event a check is returned for insufficient funds, a fee of $25 will automatically be assessed to your account.

If my account is referred to an outside collection agency, I agree to pay all costs, including attorney fees, up to the statutory limits.

I agree to pay Advance Dental Clinic for any services rendered to me or members of my family in accordance with the terms stated above.

Interest charges will be applied to accounts not paid in accordance with the above guidelines at a rate of 1.5% monthly for a compound annual rate of 18%.

I have read the above information regarding the Payment Policy and agree to its terms.

Patient/Guardian
Signature_____ Date_____

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It is our policy to confirm appointments in advance to ensure that optimal dental care is provided to you and your family at a time and day that is convenient to you. Therefore, we need to know as soon as possible if you will be unable to keep your appointment so that we may offer that time to someone who has an immediate need. Missed appointments not only create an inconvenience to us and our other patients, but also puts a financial burden on our practice when we keep staff and other resources available for appointments that are not kept. Since this time is reserved exclusively for you, we will charge a fee for appointments which are not cancelled within 48 hours of your scheduled appointment.

If you are late for an appointment and there is not enough time remaining in the schedule to complete your planned treatment before our next patient is due, we may need to reschedule your appointment. Therefore, a cancellation fee may apply.

We certainly understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations. However, we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those patients who are diligent about keeping their appointments.

If you have any questions at all about this policy, please do not hesitate to ask. We appreciate your business and your understanding of the need for this policy.

I have read the above information regarding the Appointment Cancellation Policy and agree to its terms.

Patient/Guardian
Signature_____ Date_____

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ACKNOWLEDGEMENT OF RECEIVING/READING NOTICE OF PRIVACY PRACTICES

I, _____ , have received the office's Notice of Privacy Practices.

_____

Patient/Guardian Signature

Date_____

(AVAILABLE AT FRONT DESK IN BLACK BIN)

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NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
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 practices, our legal duties, and your rights 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 (04/14/2003), 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, provide such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and in the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices,
Or for additional copies of this Notice, please contact us using the information at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician of other healthcare provider pending treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provided to you.

Healthcare operations: We may use or 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 practitioner and provider performance, conducting training programs, accreditation, and certification licensing or credentialing activities.

Our 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. You revocation will not affect any use of disclosures permitted by your authorization while it was in affect. 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 Family and Friends: We must disclose your health information to you, as described in the Patient 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, but only if you agree that we may

do so.

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 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 responsible inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other 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 to do so by law.

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, 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 the authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions 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 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 your 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 end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you 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 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 using the information at the end of this Notice for a full explanation of our fee structure.

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, health operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in 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 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).