TMJ & SLEEP APNEA CENTER OF THE GREATER WASHINGTON DC AREA

Patient Information

Patient Name: _____
Last First MI (Preferred Name) **Date**:

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse or Responsible Party Information (if not self)

The following is for: ☐ the patient's Spouse ☐ Domestic Partner ☐ the person responsible for payment

Name: _____ Gender: ☐M ☐F

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner _____

Insurance Plan Name/Adrs/Tel: _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Internet Search - Which search engine? ☐Google? ☐Yahoo! ☐MSN ☐Other_____

☐ Dr. / Dental Office ☐ Magazine/Newspaper Ad ☐Another patient ☐ Work

Name of person, office or media referring you to our practice: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please indicate YES by marking the box:

☐ AIDS / HIV
☐ Allergies
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Snoring
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Pre-medication

OTHER:
☐ _____
☐ _____
☐ _____

- Do you have any specific drug allergies? ☐ Yes ☐ No
  If yes, please list: _____
- List all of the medications you are currently taking:_____
- 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: _____

Are you interested in Aesthetic dental work to improve your smile? ☐Yes ☐No (If yes, please describe what you feel defines a beautiful and healthy smile)

Are you interested and/or considering dental implants? ☐ Yes ☐ No
Would you like information about implants and the latest technology? ☐ Yes ☐ No

Dental History

Please Circle Yes or No:

- Do your gums bleed? ☐Yes ☐No
- Are you concerned about your breath? ☐Yes ☐No
- Do you have any sores or lumps in or near your mouth? ☐Yes ☐No If yes, where _____
- Do you have or have you ever had any of the following? (Please mark box)

☐Pain in your jaw joints
☐Soreness when chewing
☐Frequent Headaches
☐Difficulty in opening or closing your mouth
☐Clenching or grinding your teeth
☐Periodontal Treatment

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.

_____ Date: _____
Signature of patient, parent or guardian

Emergency Contact Information

Name: _____

Gender: ☐M ☐F Relation: ☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Friend ☐ Other_____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

HIPAA Consent of Services

Your Health Information May be Used…

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental labs, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with the companies with a similar commitment to the security of our health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters and telephone reminders or email.

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make their disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. If there is an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

_____ Date: _____
Patient Name

Patient Rights

Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information.
Confidential Communications: You have the right to request that we communicate with you in a certain way. You may request that we only communicate our health information privately with no other family members present or through mailed communications that are sealed.
I**nspect and Copy Your Health Information**: You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your information, please let us know. We will charge you a fee of approximately $35.00 for copying and assembly.
Amend Your Health Information: You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. For standardization purposes, please provide us with a written request of your information.
Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations.
Request a Paper Copy of this Notice: You have the right to obtain copy of this Notice of Privacy Practices directly from our office at any time...

***On occasion, TMJ & SLEEP APNEA CENTER OF THE GREATER WASHINGTON DC AREA may use your image for our website and/or photobooks. Please let us know if you prefer your image not be used.**

Dental Benefit Explanation/Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

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. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

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.

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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Dental Benefit Explanation/Financial Policy

I grant my permission to you or your assignee, to call me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Cancellation and No-Show Policy

Office hours are by appointment and we reserve your appointment time for you alone. When you make an appointment, please be sure that you will be able to keep it. Morning appointments are ideal for more complicated procedures. When appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one visit. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes or delays. If you have a dental emergency that needs immediate attention, we will always do our very best to accommodate you. We also expect that other patients who might be slightly inconvenienced will understand the nature of an emergency situation. At some point, they may need the same courtesy too!

Unlike other offices, we call to confirm your appointment 24hrs in advance. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office as soon as possible. There will be a charge of $125 per 30 minutes of scheduled time for a broken appointment or cancellation with less than 24 hours' notice. For your first treatment planned appointment we will require in advance a percentage deposit of your proposed treatment plan fee in order to secure your personal block of time.

If you have any questions about our appointment cancellation and no-show policy, please feel free to speak with our office manager.

I understand the ***TMJ & SLEEP APNEA CENTER OF THE GREATER WASHINGTON DC AREA*** *Cancellation and No-Show* policy:

_____ _____

Patient Signature Date