MARYLAND
PROSTHODONTIC
ASSOCIATES
Prosthodontics and Maxillofacial Prosthetics

6569 N. Charles Street
Physicians Pavilion West, Suite 601
Baltimore, MD 21204
P - 443-519-5293
F - 443-519-5623
E - info@marylandprostho.com
www.marylandprostho.com

Registration and Health History

Patient Information

Today's Date:_____ Reason for this visit:_____

Patient's Name:_____ DOB:_____ SS#:_____

(Last) (First) (MI)

Address:_____ City:_____ State:_____ Zip:_____

Home # _____ Work # _____ Cell # _____

DL # _____ Sex: _____ Marital Status:_____

Employer: _____ Email: _____

Person to contact in an emergency _____ Phone # _____

If Patient is a minor, give parent or guardian's name _____

How did you hear about our office? _____

Dental Insurance Information

Insured's Name: _____ Relation to patient: _____

Insured's SS#: _____ DOB: _____

Insured's Address (if different than above): _____

City:_____ State: _____ DOB: _____

Insured's Employer: _____ Insurance Company: _____

Claims Address: _____

_____

Phone #: _____ Group #: _____ Effective Date of Coverage: _____

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Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your Dental Health. The information is strictly confidential and will not be released to anyone without approval. Thank you for completely filling out this questionnaire.

How long since you have seen a dentist? _____ Date you last had x-rays taken: _____

Previous Dentist's Name: _____ Last complete exam date: _____

Major dental concern? _____

Do your gums bleed while brushing or flossing?	Y	N	Do you have frequent headaches?	Y	N
Are your teeth sensitive to hot or cold liquids/foods?	Y	N	Do you clench or grind your teeth?	Y	N
Are your teeth sensitive to sweet or sour liquids/foods?	Y	N	Do you bite your lips or cheeks frequently?	Y	N
Do you feel pain to any of your teeth?	Y	N	Have you ever had any difficult extractions in the past?	Y	N
Do you have any sores of lumps in or near your mouth?	Y	N	Have you ever had any prolonged bleeding following extractions?	Y	N
Have you had head, neck or jaw injuries?	Y	N	Have you had any orthodontic treatment?	Y	N
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials?	Y	N
			If yes, date of placement _____		
Clicking	Y	N	Have you ever received oral hygiene	Y	N
Pain (joint, ear, side of face)	Y	N	instructions regarding the care of your teeth		
Difficulty in opening or closing	Y	N	and gums?		
Difficulty in chewing	Y	N	Do you like your smile?	Y	N

Medical History

Physician: _____ Office Phone: _____

List all medications you're currently taking _____

Circle any of the following medications to which you are allergic or have ever reacted adversely:

Aspirin Any Metals Barbiturates Iodine Latex Local Anesthetic Nitrous Oxide Penicillin Sulfa Other_____

Y N Are you under medical treatment now?
Y N Do you use tobacco?
Y N Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____

Women Only:
Y N Are you pregnant or think you may be pregnant?
Y N Are you nursing?
Y N Are you taking oral contraceptives?

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Check any of the following that you have had or presently have:

__ High Blood Pressure
__ Heart Attack
__ Rheumatic Fever
__ Swollen Ankles
__ Fainting / Seizures
__ Asthma
__ Low Blood Pressure
__ Epilepsy / Convulsions
__ Leukemia
__ Diabetes
__ Kidney Disease
__ AIDS of HIV Infection
__ Thyroid Problem
__ Heart Disease
__ Cardiac Pacemaker
__ Heart Murmur
__ Angina
__ Frequently Tired
__ Anemia
__ Emphysema
__ Cancer
__ Arthritis
__ Joint Replacement or Implant
__Hepatitis / Jaundice
__ Sexually Transmitted Disease
__ Stomach Troubles / Ulcers
__ Chest Pains
__ Easily Winded
__ Stroke
__ Hay Fever / Allergies
__ Tuberculosis
__ Radiation Therapy
__Glaucoma
__ Recent Weight Loss
__ Liver Disease
__ Heart Trouble
__ Respiratory Problems
__ Mitral Valve Prolapse
__ Other _____

Is there any other medical or dental information or experiences that you feel we should know about?

_____

_____

Patient Signature or Parent/Guardian of child: _____ **Date:**_____

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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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Notice of privacy practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient after February 1, 2012, and will remain in effect until we replace it.

We must make good-faith attempt to obtain written acknowledgment of receipt of the Notice to the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Therefore, we must distribute the Notice to each new patient at the time of service and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you for: (a) the provision, coordination, or management of health care and related service by healthcare providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for healthcare from one healthcare provider to another.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care review, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as, quality assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, 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 of 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.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your healthcare needs. We will never sell your health information without your prior authorization.

To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Only with your permission may we disclose your health information to a family member, friend or

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other person to the extent necessary to help with your healthcare or with payment for your healthcare. If you are unable to provide permission to release this information, we may assist, if deemed necessary by a healthcare professional.

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 locations, 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 or experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up, fill prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

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.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other heath related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review 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 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 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 listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have a 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, where you have provided an authorization and certain other activities, for the last six (6) years, but not for the disclosure made prior to February 1, 2012. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: 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 requests, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location 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 circumstance.

QUESTIONS AND COMPLAINTS: If you would like more information about our Privacy Practices or have questions or concerns, please contact us.

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If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: **PRACTICE MANAGER**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this form

I have read and received a copy of this office's: **Notice of Privacy Practices**

_____
(Please print name)

_____
Signature date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An Emergency situation prevented us from obtaining acknowledgement
- ☐ Other (specify)

_____

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Office Financial Policy

Our goal is to provide you and your family with the finest dentistry available. In this spirit, we have developed affordable services that, when performed on a timely basis, can prevent future costly procedures. Please review our financial policy. Your clarity in the administration and payment of your dental expenses will help us maintain a successful dental health relationship.

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.

Payments
Payment is expected at the time of service. For you convenience, we request a credit card number be placed on file for incidental balances. During your appointment, we will accept any of the following payment methods:

__Cash/Money Order __Check __ Credit Card: __Visa __MC __Amex
Card# _____ Exp_____ Sec Code_____

Please make necessary financial arrangements prior to treatment. All balances must be fully settled within ninety (90) days of service. If an account is outstanding for more than thirty (30) days, a monthly billing and handling charge of $5.00 will be added to that balance. In the event that your balance remains unsettled after ninety (90) days, the credit card on file will be utilized to resolve your balance. All amounts remaining unsettled after ninety days are subject to finance charges of 18% APR and may be forwarded to a collection agency. You agree to pay all fees associated with the collection of your balance (i.e. admin fees, finance charges, service fees, collection agency fees, attorney fees, etc.). You agree to pay a $25.00 fee that will be charged on all returned checks.

Emergency Dental Care
All emergency dental services, or any dental services performed, without prior written financial arrangements, must be paid for in cash or credit at the time services are performed.

Dental Insurance
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 for all dental services. We offer a valuable service to our patients, by helping to prepare the patients insurance forms, free of charge. The office will credit any such collections from insurance to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid for by an insurance company.

Minors
Age 17 and under must be accompanied by a parent or guardian for all appointments and are required to remain in the office until treatment is completed. The adult accompanying the minor is responsible for the balance due. Payment is expected at the time of service.

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Please assist us, as a partner in your dental health, by following our policies. If at any time you have questions or concerns regarding our policies or your account, please do not hesitate to contact our Practice Manager for assistance.

Dr. Ghassan G. Sinada & Staff

Please read the statement below. Sign in the space provided.
I have read and understand this financial policy and agree to the above terms. I permit Dr. Sinada and Staff to release my health information to third party payers and/or other practitioners, if necessary. I authorize and request my insurance company pay directly to myself. I accept responsibility for payment of all services rendered on my behalf and behalf of my dependents.

X_____ Date_____ Relationship to Patient_____
Patient/Parent/Guardian Signature

X_____ Date_____ Relationship to Patient_____
Guarantor of payment/Responsible Party Signature

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BROKEN APPOINTMENT CHARGE

We reserve space in our office for you and your family to receive care. Should you need to break your appointment, please let us know at least 24 hours in advance.

If an appointment is broken without advance notice, a $50.00 broken appointment fee will be assigned to your account. This is not covered through your insurance. This fee will become due as a part of your accounts balance, and it will need to be satisfied prior to scheduling future appointments.

Kindly give us notification so your appointment time can be given to another patient.

Thank you for your cooperation.

_____ _____

Please Initial Date