DENTAL CARE

19729 Executive Park Circle
Germantown, MD 20874
Ph: 301-515-0030
Fx: 301-515-0031
mail@wisteriadental.com
www.wisteriadental.com

Thank you for choosing our dental office to care for your dental needs. We are delighted to welcome you into our dental family, and appreciate the opportunity to provide you with quality dentistry and a comfortable experience.

Our desire is to enter a partnership based on trust and mutual responsibility. Please know that your needs come first in this practice, and our commitment to you is to provide you with what you value in your long-term oral health.

Our medical and dental history forms are enclosed here. As well as our notice of privacy practices. Please complete these forms and bring them with you to your appointment so that we have the important information that we need to serve you better. We will need approximately an hour or a little longer to examine clinically and radiologically (with x-rays) your teeth, gums, soft tissue and for your cleaning. The exam also includes an oral cancer screening.

We look forward to meeting you. Because this time has been reserved specially to meet your dental needs, we thank you in advance for honoring your appointment. If you have any questions before this time please do not hesitate to call the office or email at the address listed above.

Again, thank you for choosing our office for your dental needs. We look forward to a long and mutually beneficial relationship.

Sincerely,

Hema Patel, DDS & Staff

Today's Date _____

PATIENT INFORMATION

Patient # _____

Patient Name _____ Birth Date _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex □ Male □ Female □ Married □ Separated □ Widowed □ Divorced □ Single

□ Minor □ Partnered for _____ years

Home Phone # _____ Cell Phone #1 _____ Cell Phone #2 _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse/Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you?

_____

Person to contact you in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY

Name of Person responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? □ Yes □ No

Employer _____ Work Phone ( ) _____

E-mail _____ Cell Phone ( ) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone ( ) _____

Insurance company _____ Group # _____ Union or Local Number _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone ( ) _____

Insurance company _____ Group # _____ Union or Local Number _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Thank you for trusting us with your dental care.

Please note that payment is due in full at time of treatment unless prior arrangements have been approved.

Today's Date _____

PATIENT INFORMATION

Patient # _____

Reason for today's visit_____ Date of last dental care visit _____
Former Dentist_____ Date of last dental X-rays _____
Address of former dentist _____

Check (√) if you have or have had problems with any of the following

□ Bad breath	□ Grinding teeth	□ Sensitivity to hot foods
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Periodontal treatment	□ Clicking or popping jaw	□ Sensitivity when biting
□ Sores or growth in mouth	□ Food collecting between teeth	□ Sensitivity to cold foods

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen" ? These include combinations of Ionimin, Adipex, Fastin (brand names of phenteramine), Pridimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you ever had any serious illnesses or operations? □ Yes □ No
If yes, describe _____

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate date_____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (√) if you have had problems with any of the following:

□ Anemia	□ Congenital heart disease	□ Hepatitis	□ Scarlet fever
□ Arthritis, rheumatism	□ Cortisone treatments	□ Hernia repair	□ Shortness of
□ Artificial heart valves	□ Cough, persistent	□ High blood pressure	□ Skin rash
□ Artificial joints, pins etc.	□ Coughing up blood	□ HIV/AIDS	□ Stroke
□ Asthma	□ Diabetes	□ Jaw pain	□ Swollen feet
□ Back problems	□ Epilepsy	□ Kidney disease	□ Thyroidproblems
□ Bleeding abnormality	□ Fainting	□ Liver disease	□ Tobacco habit
□ Blood disease	□ Glaucoma	□ Mitral Valve Prolapse	□ Tonsillitis
□ Cancer	□ Headaches	□ Pacemaker	□ Tuberculosis
□ Chemical dependency	□ Heart murmur	□ Radiation treatment	□ Ulcer
□ Chemotherapy	□ Heart problems	□ Respiratory disease	□ Venereal disease
□ Circulatory problems	□ Hemophilia	□ Rheumatic fever	

List any medications you are taking:

_____
_____
_____

Allergies: □ None □ Aspirin □ Local Anesthetic □ Iodine □ Barbiturates (Sleeping pills)

□ Penicillin □ Latex □ Codeine □ Sulfa □ Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative_____ Date_____

_____ _____
Please print name of Patient, Guardian or Personal Representative Relationship to Patient

Thank you for trusting us with your dental care.

Please note that payment is due in full at time of treatment unless prior arrangements have been approved.

Wisteria DENTAL CARE

Hema Patel DDS, LLC
19729 Executive Park Circle • Germantown, MD 20874
PH: 301.515.0030 • FAX: 301.515.0031 • www.wisteriadental.com

Patient Treatment Consent And Financial Agreement

- I authorize Dr. Patel or designated staff treating me to perform such aids deemed appropriate to make a diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist and mutually agreed upon me.

- **This office only performs composite/resin fillings (tooth color) with exceptions. Patients are fully responsible for any difference which is not paid by the insurance company.**

- I assign all dental insurance benefits to the extent permitted under my dental insurance policy to practice. I agree and allow the provider to submit insurance forms and receive payment directly from the insurance carrier with notation "signature of file". I authorize my dentist to release treatment records/x-rays or any information deemed pertinent to my insurance carrier as necessary and/or requested.

- **I agree to pay for all services rendered on my behalf or my dependents at the time of service. I agree that my unpaid claims that the carrier does not pay or any balance that extends beyond 30 days from the date of service will be assessed a service charge of $20.00 late fee per month. In an event that this balance should be submitted to collections, there will be a fee of $100.00 charged to the account balance. If these fees should be added t your account, you will be notified by mail.**

Signature:_____ **Date:**_____

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your health care information

Treatment
We may disclose health care information to other healthcare professionals for the purpose of treatment, payment or healthcare operations. Example: on occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the practice. It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. Example: As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized bill to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Workers Compensation
We may disclose your health information as necessary to comply with state workers' compensation laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reaction to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Change of Ownership
In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your health information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to this restriction that your requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect a copy of your health information.

- You have the right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If you request to amend to your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have the right to receive an accounting of disclosures of your protected health information made by this practice.

- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This practice reserved the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all of the information that it maintains. Until such amendment is made, this practice is required by law to comply with this notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if your want more information about your privacy rights please contact our privacy officer by calling this office.

Complaints
Complaints about your privacy rights or how this practice has handled your health information should be directed to your privacy officer by calling this office. If you are not satisfied with the manner in which this office handles your complaint,you have submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ___/___/_____
I have read the Privacy Notice and understand my right contained in the notice.

By way of my signature, provide this practice with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment ,payment, and health care operations as described in the Privacy Notice.

_____
Patient's Name (Print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date