SENECA DENTAL CARE

Erica Ford, DDS
20 Executive Park Court
Germantown, MD 20874
301-916-5800

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Patient Name: Last _____ First_____ M.I. _____
Address: Street_____City_____State_____Zip_____
Email: _____
Phone Number: _____ □ Home □ Cell □Office
Phone Number: _____ □ Home □ Cell □Office
Phone Number: _____ □ Home □ Cell □Office
Birthdate: _____ Sex (for insurance): _____
Social Security Number _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name: Last _____First_____M.I._____ Marital Status: _____
Address: Street_____City_____State_____Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____ Email:_____
Relationship to Patient: _____
Social Security Number: _____

EMERGENCY CONTACT

Name: _____ Relationship:_____
Phone Number: _____ □ Home □ Cell □Office

HEALTH HISTORY

Physician's Name: _____Office Phone: _____ Date of Last Visit: _____

Please check if you have/had any of the following:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
AIDS/HIV			Epilepsy			Radiation Treatment		
Anemia			Fainting or dizziness			Respiratory Disease		
Arthritis, Rheumatism			Glaucoma			Rheumatic Fever		
Artificial Heart Valves			Headaches			Scarlet Fever		
Artificial Joints			Heart Murmur			Shortness of Breath		
Asthma			Heart Problems			Sinus Trouble		
Back Problems			Hepatitis Type _____			Skin Rash		
Bleeding abnormally, with extractions or surgery			Herpes			Special Diet		
Blood Disease			High Blood Pressure			Stroke		
Cancer			Jaundice			Swollen Feet or Ankles		
Chemical Dependency			Jaw Pain			Swollen Neck Glands		
Chemotherapy			Kidney Disease			Thyroid Problems		
Circulatory Problems			Liver Disease			Tonsillitis		
Congenital Heart Lesions			Low Blood Pressure			Tuberculosis		
Cortisone Treatments			Mitral Valve Prolapse			Tumor or growth on head or neck		
Cough, persistent or bloody			Nervous Problems			Ulcer		
Diabetes			Pacemaker			Venereal Disease		
Emphysema			Psychiatric Care			Weight Loss, unexplained		
Women: Are you pregnant?			Are you nursing?			Taking birth control pills		

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DENTAL HISTORY

Previous Dentist: _____ **Date of Last Exam:** _____
Reason for today's visit _____
How often do you brush? _____ **How often do you floss?**_____

Please check if you have/had any of the following:	Yes	No		Yes	No		Yes	No
Bad breath			Fingernail biting			Mouth pain with brushing		
Bleeding gums			Food collection between teeth			Orthodontic treatment		
Blisters on lips or mouth			Foreign objects			Pain around ear		
Burning sensation on tongue			Grinding teeth			Periodontal treatment		
Chew on one side of mouth			Gums swollen or tender			Sensitivity to cold/hot		
Cigarette, pipe, or cigar smoking			Jaw pain or tiredness			Sensitivity to sweet/sour		
Clicking or popping jaw			Lip or check biting			Sensitivity when biting		
Dry mouth			Loose teeth or broken fillings			Sores/growth in mouth		
E-cigarette/Vaping			Mouth breathing			Other _____		

ALLERGIES/ MEDICATIONS

Please check if you have/had any of the following:	Yes			Yes			Yes
Aspirin			Latex			Other (Please describe)	
Barbiturates (Sleeping pills)			Local Anesthetic			_____	
Codeine			Penicillin			_____	
Iodine			Sulfa			_____	

List any medications you are currently taking and the reason
(Please use additional sheets, if necessary):

_____
_____
_____
_____
_____

AUTHORIZATION AND RELEASE

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am ultimately responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me, if I have paid the dental fees incurred. I further understand that a late charge may be added to any overdue balance. If legal action becomes necessary to collect fees due to the office, the undersigned agrees to pay all reasonable costs of such action including attorney's fees and collection costs. There may be a broken appointment fee if 24-hour notice is not given to reschedule or cancel an appointment.

_____ _____
Signature of Patient (Parent/Guardian) Date

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the State of Privacy Practices for Seneca Dental Care. The Statement of Privacy describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the facility.

Seneca Dental Care reserves the right to change the privacy practices that are described in the statement of Privacy Practices. If privacy practices change, you will be offered a copy of the revised Statement of Privacy Practices. At the time of your first visit after the revisions become effective. You may also obtain a copy of the Statement of Privacy Practices by requesting one to be mailed to you.

ADDITIONAL DISCLOSURE AUTHORITY

Patient Name (Please Print):_____

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the persons indicated below:

Please Check:

☐ Any Member of My Immediate Family ☐ Spouse Only

☐ Other Please Specify _____

_____ _____
Signature of Patient (Parent/Guardian) Date

Broken Appointment and Cancellation Policy Consent

We require 24 hour advanced notice when canceling an appointment that has been reserved for you. If you fail to abide by the 24-hour rule, you will be charged a $50 missed appointment fee.

Depending on the nature of the cancellation, any combination of failing to give adequate cancelation notice or not showing for 2 appointments in a 6-month time span may result in DISMISSAL form Seneca Dental Care.

I acknowledge that I have been informed of the broken appointment and cancelation policy held by Seneca Dental Care. I have read the above policy and agree to abide by it.

_____ _____
Signature of Patient (Parent/Guardian) Date

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General Consent for Treatment

I hereby consent to the performance of dental treatment upon _____ _____ by Seneca Dental Care. Such treatment will be explained to me and will not proceed without my acceptance. I reserve the right to ask specific questions before recommended treatment commences. The nature and purpose of the treatment rendered, possible hazards, and alternative methods of treatment will be fully explained to me. I understand the risk involved with treatment. No guarantee, warranty, or insurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of Seneca Dental Care.

Photographs:
Seneca Dental Care may request photographs to be taken for certain procedures. These photographs are for insurance, laboratory, patient education, and advertising purposes. Photographs will not be taken without verbal consent from the patient. All photographs and/or duplications are property of Seneca Dental Care.

Who may we thank for referring you to our practice?

☐ Website ☐ Insurance Company

☐ Community Event ☐ Other _____

Name of person or office referring you to our practice _____

Agreement to Receive Electronic Communication

Patient Name:_____ **Date of Birth:**_____

I agree that the dental practice may communicate with me electronically at the email address and/or texting below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling: **301-916-5800. Standard message and data rates will apply.**

Email Address:_____

Cellphone Number (for texting notifications):_____

_____ _____
Signature of Patient (Parent/Guardian) Date

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Financial & Insurance Policies

We are pleased that you have chosen our practice for your dental care. Our goal is not only to treat you, but also to educate you on how to prevent dental disease. Our mission is to provide you with the highest quality dental care in a pleasant surrounding and as efficiently possible. Please read and sign the following policies.

Insurance Polices

- Insurance companies do not cover 100% of all dental expenses. It is your responsibility to be familiar with restrictions, limitation, and deductions that may apply to your plan. Your portion not covered by insurance is due at the time treatment is rendered. Please understand that dental insurance is a contract between you and your insurance carrier. You are still the responsible party regarding dental treatment fees; as a courtesy to you we will submit claims to your insurance company for you.
- All deductible and co-payments must be satisfied at the time treatment is rendered. Please understand that the requested amount of co-payment or co-insurance is **approximated** based on the information received form your insurance company. All claims that are rejected or adjusted by the insurance company will become your additional responsibility and payable to Seneca Dental Care immediately.
- If Seneca Dental Care is not participating with your insurance, payment is expected in full at the time of service unless prior arrangements have been made. We will provide you with a statement of services rendered to submit to your insurance carrier once the balance is paid in full.
- All insurance claims not paid within 60 days of submission to the insurance company are due and payable by the patient.

Financial Policies:

- We are available for you after hours and on Saturdays if you have an emergency; there will be a charge of $475.00 in addition to your treatment fees.
- We offer flexible no-interest or low-interest payment plans. Financing is subject to credit approval by the participating financial group. For your convenience, we accept Cash, Check, Master Card, Visa, and American Express.
- Balances over 30 days old will accrue an interest charge of 1.5% monthly or 18% annually and a $15.00 monthly late fee if payment is not received by the due date. If it becomes necessary to refer your account to a collection agency, you will be responsible for all expenses including but not limited to court costs, reasonable attorney's/collection fees, an account service fee of $25.00, and a surcharge of 40%.
- Returned checks are subject to a $50.00 service charge.
- Broken and cancelled appointments are subject to $50.00 per half hour charge. Twenty-four hour notice is required to avoid such charges. More information available on Broken Appointment and Cancellation Policy Consent Form
- Procedures that involve laboratory work i.e. crowns, dentures, etc. If you fail to maintain you appointment for delivery of your case, you are responsible for laboratory fees in full and 50% of all procedure fees.
- All patients under the age of eighteen MUST be accompanied by a parent or guardian. A parent or guardian MUST remain on site while treatment is rendered.
- Copies of your x-rays and records are available at your request. We require a written request forty-eight (48) hours prior. There is a $15 processing fee for copies of your most recent x-rays.

_____ _____

Signature of Patient (Parent/Guardian) 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are describe in this Notice while it is in effect. This Notice takes effect 10/01/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment – We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment – We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations – We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care – We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief – We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities – We may disclose your health information for public health activities, including disclosures to:

- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security – We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody the protected health information of an inmate or patient.

Secretary of HHS – We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation – We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement – We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities – We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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Judicial and Administrative Proceedings – If you are involved in in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party to us, to tell you about the request or to obtain an order protecting the information requested.

Research – We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors – We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising – We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access – You have the right to look to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting – With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction – You have the right to request additional on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication – You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location that you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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 circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach – You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice – You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic main (e-mail).

Questions and Complaints

If you want 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 if you disagree with a decision we made about access to your health information or in response to a request you made to amend or resist 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 may also 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.

Our Privacy Official: SENECA DENTAL CARE – Office Manager
Telephone: (301) 916-5800
Address: 20 Executive Park Ct., Germantown, MD 20874
Email: senecadental@gmail.com