Wade Family Dentistry

REGISTRATION FORM

Section I: **Patient Information** Date_____

Name:_____ I preferred to be called:_____

Address:_____City:_____ State:_____ Zip:_____

Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. on my ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Date of Birth:_____ Social Security Number_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School: _____City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer:_____ Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of emergency? _____ Phone_____

Email Address:_____

Section II: **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____Relationship to Patient:_____

Address:_____

City:_____State:_____Zip:_____Phone:(_____)_____

Employer_____ Work Phone (_____)_____ SSN#_____

Section III: **Insurance Information**

Name of Insured:_____ DOB_____ Relationship to Patient_____

SSN#_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____ City:_____ State: _____ Zip:_____

Insurance Company:_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co Phone:_____

------- DO YOU HAVE ADDITIONAL INSURANCE? ☐Yes ☐No IF YES, COMPLETE THE FOLLOWING: --------

Name of Insured:_____ DOB_____ Relationship to Patient_____

SSN#_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____ City:_____ State: _____ Zip:_____

Insurance Company:_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co Phone:_____

WADE FAMILY DENTISTRY

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

WADE FAMILY DENTISTRY
Hillary S. Wade, D.D.S., Chartered
1855 Howell Road
Hagerstown, MD 21740
(301) 739-4114

AKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ (please print your name) have received a copy of our *Notice of Privacy Practices* regarding the **HIPPA** laws.

_____
Patient's Name, if a **MINOR** (please print)

_____ _____(SEAL)
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
( ) Communication barrier prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other, please specify _____
_____
_____

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1855 Howell Road
Hagerstown, MD 21740
(Ph) 301/739-4114 (Fax) 301/739-6294

PRACTICE POLICY AGREEMENT

If you decline to sign this portion, you must pay for all the services in full when they are rendered. When you are given a dental estimate of patient responsibility, *it is due at the time of service*. Upon request, we will let you know in advance what your estimate will be, and you will be required to pay that amount at the time of your appointment. **There will be no exceptions to this rule**. You are responsible for providing our office accurate dental insurance information. We will submit your dental claims to your insurance carrier only once.

I HAVE HEREBY BEEN INFORMED OF THE FOLLOWING:

- All broken appointments, either failed, or cancelled with less than a **24 hour verbal notice**, will incur a charge of $50.00. This notice includes ***business days*** only. For example, if you want to cancel a Monday appointment scheduled for 9:00 AM, you have to cancel by 9:00 AM the Friday before. Also, appointments scheduled on a Monday, or the Tuesday after a Monday holiday, need to be cancelled by 5:00 PM the Thursday before. As a courtesy, we will make every attempt to call you and remind you of your appointment day and time.
- All returned (insufficient funds) checks will incur a charge of $35.00 per check.
- A $25.00 delinquency fee will be applied to your balance on past-due accounts after 30 days.
- If it is necessary for us to retain an attorney to settle an outstanding bill, a 25% attorney fee may be applied to your balance if the case goes to *Judgment*.
- If your insurance company does not pay for a claim for any reason, we will charge you the allowable fees.

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing the incorrect medical, contact and/or emergency information, can be dangerous to my health. I authorize the dentist to release any information, including diagnosis and records of any treatment or examination rendered to me, or my children during the period of such dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services rendered. I hereby agree to be responsible for prompt payment of all services rendered on my behalf, or my dependents.

Patient's name (print):_____

Signature of responsible party:_____**(SEAL)**

Relationship to patient:_____

Date of Signature:_____

WADE FAMILY DENTISTRY

Hillary S. Wade, D.D.S., Chartered
1855 Howell Road
Hagerstown, MD 21740
Office (301) 739-4114
Fax (301) 739-6294
Email: info@wadefamilydentistry.com
Contact: Shelley M. Sachariah, Insurance/Billing

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 REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations, Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we do in order to run our office. Example of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans, defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims or suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for adults by Medicare or Medicaid; or for investigation of possible violations of health care laws;

- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim in a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to Worker's Compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you or other treatments of services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form: is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate theses requests if they care reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day

extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to person who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information alone with any rebuttal statement that we may write. Once your statement of position and /or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got on electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this notice.