Maryland Dental
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION FORM

Please **fax the completed form to (301) 869-7703** or bring in the completed form with you on your first appointment. Faxing the completed form ahead of time, will save you time during your visit and help us to be prepared for your appointment. **Feel free to contact us at (301) 869-7733** should you have any questions. All patient information is confidential.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Address, City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Birth Date: _____ SS #: _____ Patient is: ☐ Policy Holder ☐ Responsible Party

RESPONSIBLE PARTY (IF SOME ONE OTHER THAN THE PATIENT)

First Name: _____ Last Name: _____ Middle Initial: _____

Address, City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Birth Date: _____ SS #: _____

Responsible Party is: ☐ Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

SECTION - A

Employment: ☐ Full-Time ☐ Part-Time ☐ Retired

Employer Name: _____

Employer Address: _____

City, State, ZIP: _____

Student: ☐ Full-Time ☐ Part-Time

Name of the school attending: _____

SECTION - B

Physician Name & Phone # _____

Emergency Contact & Phone # _____

Pref. Pharmacy & Phone # _____

Heart Conditions: ☐ Yes ☐ No

Joint Replacement: ☐ Yes ☐ No

Any Conditions requiring pre-medications: ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

Name of insured (First,Last) _____ Relationship of Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security # _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Employer Address: _____ Policy/Group/ID # _____

City, State, ZIP _____ Insurance Company Phone # _____

SECONDARY INSURANCE INFORMATION

Name of insured (First,Last) _____ Relationship of Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security # _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Employer Address: _____ Policy/Group/ID # _____

City, State, ZIP _____ Insurance Company Phone # _____

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include referral services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family member, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of Aug 1st, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices form this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against your for filing a complaint.

Please contact us for more information

Maryland Dental
15204 Omega Dr. Ste 140
Rockville, MD 20850
Tel: (301) 869-7733
www.mddental.com

For more information about HIPPA Or to file a complaint

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Note: Your signature will be taken in the office during your first visit