TOWSON
DENTAL CARE

Craig L. Snyder, DDS
300 East Joppa Road, Suite 400, Towson, Maryland 21286
Phone (410) 296-3993 Fax (443) 519-5474
www.TowsonDentalCare.com

Patient Registration and Health History

Patient Information

Today's Date_____

Name: _____
Last Name First Name Middle Initial

I prefer to be called: _____ Age: _____

☐ Male ☐ Female Birthdate: ___/ ___/ ___

SS#: _____

Address: _____

City: _____

State: _____ Zip Code: _____

E-mail Address: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Separated ☐ Minor ☐ Partnered for _____ years

Home #(_____)_____ Cell#(_____)_____

Work #(_____)_____ ext _____

Occupation: _____

Employer/ School: _____

How long there? _____

Where and when are best times to reach you?

_____

Whom may we thank for referring you?

_____

Other family members seen by us:

_____

Person Responsible for Account: _____

Work # (____)_____ Home # (____)_____

Billing Address: _____

Relationship: _____ SS#_____

Employer: _____

Emergency Contact

Name: _____ Relationship: _____

Home # (____)_____ Cell #(___) _____

Work # (____)_____ Ext _____

Address: _____

Spouse Information

His/Her Name: _____

Employer: _____

SS# _____ Birth date: ___/ ___/ ____

Dental Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

ID #: _____

Insured Name: _____

Relationship: _____ Insured Birthdate: ___/ ___/ ___

Insured Employer: _____

Employer's Address: _____

Secondary insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

ID #: _____

Insured Name: _____

Relationship: _____ Insured Birthdate: ___/ ___/ ___

Insured Employer: _____

Employer's Address: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Date of last Visit:_____ Phone #(_____)_____

Are you currently under the care of a physician?

☐ Yes ☐ No

Please Explain: _____

_____

Your current general health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco? ☐ Yes ☐ No

If yes, what and how much? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many per week? _____

Medical History Continued

Have you been hospitalized for any reason? ☐ Yes ☐ No
If so, explain: _____

Are you taking any prescriptions, over-the-counter or herbal medications? ☐ Yes ☐ No
Please list each one: _____

Have you ever taken Fosamax or other medications for osteoporosis? ☐ Y ☐ N

For Women

Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #_____
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?
Please circle Y or N

OY NO Abnormal Bleeding
OY NO Acid Reflux
OY NO Alcohol/Drug Abuse
OY NO Anemia
OY NO Arthritis
OY NO Artificial Bones/Joints/Valve
OY NO Asthma
OY NO Blood Transfusion
OY NO Cancer/Chemotherapy
OY NO Colitis
OY NO Congenital Heart Defect
OY NO Diabetes
OY NO Difficulty Breathing
OY NO Emphysema
OY NO Epilepsy
OY NO Fainting Spells
OY NO Frequent Headaches
OY NO Glaucoma
OY NO Hay Fever
OY NO Heart Attack
OY NO Heart Murmur
OY NO Heart Surgery
OY NO Hemophilia
OY NO Hepatitis
OY NO Herpes/Fever Blisters
OY NO High Blood Pressure
OY NO HIV+/AIDS
OY NO Infective Endocarditis
OY NO Kidney Problems
OY NO Liver Disease
OY NO Low Blood Pressure
OY NO Lupus
OY NO Mitral Valve Prolapse
OY NO Osteoporosis/ Paget's Disease
OY NO Pacemaker
OY NO Psychiatric Problems
OY NO Radiation Treatment
OY NO Rheumatic/Scarlet Fever
OY NO Seizures
OY NO Sexually Transmitted Disease (STD)
OY NO Shingles
OY NO Sickle Cell Disease/Traits
OY NO Sinus Problems
OY NO Stroke
OY NO Thyroid Problems
OY NO Tuberculosis (TB)
OY NO Ulcers

Please list any serious medical condition(s) that you have ever had:
_____

Allergies

Are you allergic to any of the following?
Please circle Y or N

OY NO Aspirin
OY NO Clindamycin
OY NO Codeine
OY NO Dental Anesthetics
OY NO Erythromycin
OY NO Ibuprofen
OY NO Latex
OY NO Penicillin
OY NO Other

Please list any other drugs/materials you are allergic to:
_____

Dental History

Reason for today's visit? _____
Date of last dental visit: _____
Former Dentist: _____
Date of last dental x-rays: _____

Do you require antibiotics before dental treatment? OY NO
Are you currently in pain? OY NO
Have you ever had a serious/difficult problem associated with any dental treatment? OY NO
Have you ever had gum treatment? OY NO
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? OY NO
Are you happy with your smile? OY NO
Would you like a whiter smile? OY NO
Would you be interested in straighter teeth? OY NO
Do your gums bleed? OY NO
Are your teeth sensitive to heat/cold/or anything else? OY NO
If yes, describe _____
Have you lost any teeth? OY NO
If yes, why? _____
Do you have any dental anxiety or fear? OY NO
Describe _____
Do you clench or grind your teeth? OY NO

Your current dental health is: ☐ Good ☐ Fair ☐ Poor
How many times a week do you floss? _____
How many times a day do you brush your teeth? _____
Type of bristles?
☐ Soft ☐ Medium ☐ Hard ☐ Electric Toothbrush

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature (Guardian if minor) Date

Payment is due in full at time of treatment
unless prior arrangements have been approved.

This office accepts insurance, therefore I understand that I am responsible for payment of the service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature (Guardian if minor) Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

Craig L. Snyder, DDS
300 East Joppa Road, Suite 400, Towson, Maryland 21286
Phone (410) 296-3993 Fax (443) 519-5474
www.TowsonDentalCare.com

Practice Guidelines and Financial Policy

WELCOME to our practice, it is our pleasure to have you as our patient. Our mission at Towson Dental Care is to provide a quality dental experience in a comfortable and caring manner, helping each patient achieve the healthy beautiful smile they deserve. We are proud of our commitment to our patients, our community and the environment. Our knowledgeable and highly trained team is dedicated to excellence in comprehensive dental care while building lifelong relationships.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the information below or insurance coverage, please do not hesitate to ask...we are here to help.

Appointment Guidelines

☐ In the event that you are unable to keep your reserved appointment time, we ask that you give us **48 hours notice**, so that we may offer this time to another patient in need of care. As long as we receive this notice we can guarantee there will not be a charge. If something unforeseen should occur, the fee for a missed appointment is $50 per appointment hour. This fee will be assessed on a case-by-case basis.

Insurance Benefits

☐ If you are a patient with dental benefits, it is important to remember your dental plan is a contract between you, your employer, and your dental insurance carrier. Dental insurance is a limited benefit and can have specific coverages and exclusions. We accept assignment of benefits as a courtesy to our patients. We submit an insurance claim for services as they are rendered. Therefore accurate insurance information is necessary for correct billing. The estimate provided by this office is to be considered a guideline, not a quote, until the final insurance payment is received. **Ultimately you are responsible for all the cost of treatment. All unpaid insurance balances are due and payable from the patient after 60 days.**

Financial Understanding and Guidelines

☐ **Private Payments and Insurance Deductibles and Estimated Co-Payments are due in full at the time service is rendered.** We accept Cash, Checks, MasterCard, VISA, and Discover Card. Outside financing is available through Care Credit upon approval. Returned checks and outstanding balances over 60 days are subject to collection fees. *Submission to treatment implies your consent to terms of this agreement.*

Changes in Personal Information

☐ Please notify us of any changes in your medical history, any changes in your medications, telephone numbers, address or insurance information as soon as possible so that we may keep your file information current and accurate.

_____ (Initials) **I acknowledge that I have read the HIPAA Notice of Privacy Practices.**
A copy is available for you take with you upon request.

Patient Signature_____ Date: _____

Print Name_____

TOWSON
DENTAL CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
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 (Please Specify)

_____

_____

_____

Towson Dental Care

Request for Access or to Disclose Protected Health Information

Policy Number: _____
Effective Date: _____
Last Revised: _____

[PATIENT] Name: _____ Date of Birth: _____

Request for Access or Transfer: (*Check which applies*)

☐ I request access and/or copies of my Protected Health Information ("PHI").

I request Towson Dental Care to transfer a copy of my PHI.

If requesting a transfer, who will be receiving the requested PHI? (*Please provide the following information about the recipient.*)

Towson Dental Care	info@towsondentalcare.com
300 East Joppa Rd., Suite 400	Towson, MD 21286
410.296.3993	443.519.5474

Description of Records or Information to Access or Copy: (*Specify type of disease, accident, dates of treatment, or other portion of information you are interested in*)

_____

_____

I would like a copy of my PHI sent via the following method of transmittal: (*Check only one*)

☐ U.S. Mail
☐ In person pick-up by patient at the office
☐ Secured/Encrypted E-mail
☐ Unsecured/Unencrypted E-mail**

** I understand that I have requested Towson Dental Care transmit my PHI through unsecure/unencrypted e-mail. I have been warned that there are potential security risks to my PHI in the transmission of such unsecured methods and Towson Dental Care is not liable for any potential security risks such as unauthorized disclosures of PHI associated with the transmittal of such PHI through unsecure/ unencrypted e-mail. Further, Towson Dental Care is not liable for what happens to the PHI once the designated third party receives the information as directed by my access request. By signing below, I agree to accept the risk that my PHI is being sent via unsecure/ unencrypted e-mail.

Signature: _____ Date: _____

Towson Dental Care
300 East Joppa Rd
Suite 400
Towson
Maryland, 21286

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Towson Dental Care understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 06/06/2019, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

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.

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 official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

PATIENT RIGHTS

Access: You have the right to look at 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, mailing, 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 the 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 and certain other activities, for the last 6 years, but not before April 14, 2003. 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 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 restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 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 circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Kathleen Snyder RN
Telephone: 4102963993
E-mail: info@towsondentalcare.com
Address: 300 East Joppa Rd
Suite 400
Zip Code: 21286
State: Maryland
City: Towson