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: _____

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

Allergies

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

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

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

Doctor's Comments: _____