Harbor Dental Center

PATIENT REGISTRATION

Effective 2/15/2018

Patient Last Name: ______________________ **First:** ______________________ **Initial:** __________

How do you wish to be addressed (nickname)? ______________________

Date of Birth: ______________________ Social Security Number: ______________________

Address ______________________

City ______________________ State/Zip ______________________

Cell Phone ______________ Work ______________ Home ______________

Email ______________________

Best method to reach you ______________________ May we send text/email appointment reminders? ☐ Yes ☐ No

How did you hear about our practice? If you were referred by someone, please tell us so we can thank them!

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INSURANCE INFORMATION ☐ ***Check here if you do not have dental insurance***

Primary Dental Insurance	Secondary Dental Insurance
Insurance Company ______________	Insurance Company ______________
Subscriber Name ______________	Subscriber Name ______________
Date of Birth ______________	Date of Birth ______________
Subscriber ID ______________	Subscriber ID ______________
Group Number ______________	Group Number ______________
Relationship to Subscriber ☐Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber ☐Self ☐ Spouse ☐ Child ☐ Other
Employer Name ______________	Employer Name ______________

RESPONSIBLE PARTY (*If minor)*

Last Name: ______________________ First: ______________________ Initial: __________

Address (*If different)* ______________________

City ______________________ State/Zip ______________________

Cell Phone ______________ Work ______________ Home ______________

Email ______________________

EMERGENCY CONTACT

Last Name: ______________________ First: ______________________ Initial: __________

Cell Phone ______________ Work ______________ Home ______________

AUTHORIZATION

I consent to the diagnostic procedure and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS: I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by notifying the office.

I attest to the accuracy on this page.

Signature ______________________ Date______________

(Responsible Party, if under 18)

Harbor Dental Center

MEDICAL HISTORY

Effective 2/15/2018

PATIENT NAME: ____________________ **DATE OF BIRTH:** ____________________

MEDICAL HISTORY					
		Please circle if you have/had:			***Please circle if you have/had:***
Y	**N**	Acid Reflux	**Y**	**N**	Heart surgery
Y	**N**	AFib	**Y**	**N**	Immune system disorder
Y	**N**	Angina	**Y**	**N**	Insulin resistant
Y	**N**	Anxiety/Depression	**Y**	**N**	Hepatitis (type________________)
Y	**N**	Arthritis	**Y**	**N**	Herpes
Y	**N**	Artificial heart valves	**Y**	**N**	High blood pressure
Y	**N**	Artificial joints	**Y**	**N**	Kidney disease
Y	**N**	Asthma	**Y**	**N**	Liver disease
Y	**N**	Bleeding/Clotting disorder	**Y**	**N**	Lung disease
Y	**N**	Bone density deficiency	**Y**	**N**	Mitral valve prolapse
Y	**N**	Cancer: (Type ______________________________)	**Y**	**N**	Nervousness
Y	**N**	Chemotherapy	**Y**	**N**	Pacemaker
Y	**N**	Cholesterol	**Y**	**N**	Pain in jaw joints
Y	**N**	Cold sores/fever blisters	**Y**	**N**	Pituitary/Adrenal disorder
Y	**N**	COPD/Emphysema	**Y**	**N**	Radiation treatment
Y	**N**	Diabetes Type: ____________	**Y**	**N**	Seizures
Y	**N**	Epilepsy	**Y**	**N**	Sinus trouble
Y	**N**	Fainting/dizzy spells	**Y**	**N**	Sleep apnea
Y	**N**	Fibromyalgia	**Y**	**N**	Do you have a stent?
Y	**N**	Gastrointestinal disease	**Y**	**N**	Stroke
Y	**N**	Headaches	**Y**	**N**	Thyroid problems
Y	**N**	Heart attack	**Y**	**N**	Ulcers/Colitis/Irritable bowel syndrome
Y	**N**	HIV/AIDS	**Y**	**N**	Do you snore?
Y	**N**	Heart Murmur	**Y**	**N**	Do you smoke?

Height: ________________ Weight: ________________

ALLERGIES	**Y**	**N**	
Codeine			Other allergies not listed: ____________________________________
Erythromycin			____
Penicillin			
Sulfa			

WOMEN ONLY		
Are you pregnant? ☐ Yes ☐ No	Nursing? ☐ Yes ☐ No	Taking birth control pills? ☐ Yes ☐ No

Physician's Name ____

Physician's Phone ____

Pharmacy ____ Phone ______________________

Harbor Dental Center

MEDICAL HISTORY

Effective 2/15/2018

Have you ever had any serious illness, operations, or hospitalizations? ☐ Yes ☐ No

If yes, describe ____

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PATIENT NAME: ______________________ **DATE OF BIRTH: ______________**

MEDICATIONS

Please list all medications you are currently taking including vitamins:

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AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature ______________________ Date ______________

Reviewed by: ______________________ Date ______________

DENTAL HISTORY

Patient Name: ____ Date: ________________________

Reason for your visit today: ____

You believe your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment due to joint replacement, heart conditions or other medical problems?

☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Are you under stress? (new job, moving, relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss per week? _________ brush per day? ________

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? ____

When was your last dental visit? ____

Why did you leave your previous dentist? ____

How can we accommodate you better during your dental visit? ____

Do you have any specific concerns with your teeth? ____

Here at Harbor Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Smile Makeover	Clear Correct Invisible Braces
Sealants	Crown and Bridge	Bonding
Partials/Dentures	Implants	Snore Guards
Veneers	Night/Sport Guards	Botox/Dermal Fillers

1. Do you consider yourself to be a proactive person? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money, and/or pain to fix down the road?

   Yes ________________________ No ________________________

2. Do you consider yourself more of a reactive person? Someone who would rather wait and deal with any issues as they develop. Even if it means costing you more time, visits, money, and/or pain to fix down the road?

   Yes ________________________ No ________________________

3. What do you most value in a dental office? (Please check your most important values)

	Cosmetic	You most value how your teeth look. You want them straight and white
	Function	You most value an ability to enjoy your favorite food and drink
	Comfort	You most value NOT being in pain or having sensitive teeth or gums
	Longevity	You most value the ability to have your natural teeth forever

4. What is the biggest obstacle you have for visiting a dental office?

	No obstacles	I come faithfully every 6 months and value my dental health
	Fear	Fear or pain, noises, environnement, past experiences
	Time	Time schedule. Not being able to get off work, getting in and out of the office quickly
	No Urgency	Nothing really hurts so I haven't seen the need to go to the dentist
	Budget	I knew I needed a lot of work but did not have the money to address the issues found
	No Trust	Bad previous experience with my previous dentist, felt ripped off, or did not see the need for treatment that was recommended

Harbor
Dental Center

Effective 1/01/2019

FINANCIAL POLICIES

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and discussing payment options. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

For all patients (with or without insurance):

- ✓ To be seen by a dental professional, our Patient Registration and Medical History form must be completed in entirety and signed.
- ✓ We accept cash, check, money order, American Express, Discover, Mastercard, Visa, and CareCredit.
- ✓ Checks that are returned to our office from your financial institution are subject to a $35 returned check fee. Should this occur, we reserve the right to refuse payment via check from your or *anyone* on your account.
- ✓ If dentures, partial dentures, crown, implant, bridge, or nightguard are to be fabricated, a **50% deposit** will be required at the time of the first impression/appointment. The remaining balance will be due at the time the prosthesis is cemented/inserted.
- ✓ A finance charge of 1.5% (18% APR) will be applied to accounts with balances longer than 30 days. In addition, a minimum $10 late fee for payments not received by the date due may be assessed.
- ✓ Any appointment which is scheduled for more than 1.5 hours will require a deposit. The amount will be discussed at the time of scheduling.
- ✓ If your account is sent to an outside agency for collection of payment, it will become inactive and no further appointments will be scheduled on your behalf.

Regarding Insurance:

- ✓ Your complete insurance information must be presented prior to every appointment. This allows our staff to verify your dental benefits and coverage prior to services being rendered.
- ✓ We manage all billing of your primary and/or secondary insurances for all services provided. Any questions regarding coverage, non-payment, benefit or payments different than expected, should be directed to your insurance company. Your dental policy is a contract between you and them and is not the responsibility of our staff. Please contact your dental insurance company with any questions you may have.
- ✓ *Certain insurance companies which we are not in network with (Delta Dental of PA and CareFirst) will not provide payment for services to our office. Instead, they send payment to the patient/subscriber for allowed fees for the date of service.* ***For these companies, we require payment upfront at all appointments unless prior arrangement have been made***.
- ✓ All "estimated" patient portions (including co-pays and deductibles) are due at the time services are rendered. We can only "estimate" patient fees as dental insurance companies reserve the right to refuse any service at any time for any reason. Dental insurance benefits are determined by each patient's dental contract and each contract is different – even within the same employer.
- ✓ If your dental plan pays more than estimated, you will receive a credit on your account in that amount. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determines that you were not eligible for coverage, you will be responsible for the entire balance.

General Office Policies:

- ✓ Appointments are time we reserve just for you. Therefore, we ask for a notice of **two(2) business days** to cancel a reserved appointment. This allows us to offer your reserved appointment time to another patient.
- ✓ Appointments cancelled within 24 hours of the appointed date/time may be subject to a cancellation fee.
- ✓ All no-show appointments may be subject to a missed appointment fee. After two(2) no show appointments, your account will become inactive and no further appointments will be scheduled on your behalf without prepayment for the appointment to be made at the time the appointment is scheduled.

I authorize payment to be made to Harbor Dental Center/Dr. Meredith Todd by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance carrier. I agree to contact the office promptly if a temporary financial situation affects timely payment of my account. I hereby agree that in the event of default of any amount due, and if my account is placed with a collection agency or attorney for collection or legal action, to pay all collection fees, court costs and reasonable attorney's fees. I have read the above Financial Policy and agree to its terms.

____ _______________

Signature of Patient/Guardian Date

____

Printed Name

Out of Network Consent Form

Harbor Dental Center

402 Muse Street, Cambridge, MD 21613

At Harbor Dental Center, we believe that the doctor-patient relationship is of utmost importance and that the insurance company should not have a say in the quality of care you receive. We choose to be out of network because it allows us to take more time with you, to use the best materials and technology available, and to give you the best care we can. To this end, Harbor Dental Center is an out of network, non-participating facility for all insurance companies. We are happy to file claims on your behalf as a courtesy, but what your insurance covers is dependent on your contract with them which we have no control over.

I understand Harbor Dental Center is not a participating provider in my insurance network and that I will be financially responsible for any additional out of pocket cost that may result. I understand that if I receive services by Harbor Dental, my out of network benefits will apply. I may have additional out of pocket expenses not covered by my insurance for which I will be personally responsible. I also understand that in some instances, my insurance may not cover any benefit at all. I further acknowledge that this is my responsibility to verify my out of network benefits with my insurance company and will not hold Harbor Dental Center liable for any obscure or omitted contractual language in my insurance contract.

Print name: ____

Signature: ____

Date: ____

I have received and reviewed a copy of our dental practice's privacy policy, security and breach information policies and procedures.

I understand that I should ask the dental practice Privacy Official if I have any questions about these policies and procedures.

Print Name: ____

Signature: ____

Date: _________________

For Office Use Only Below

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- The individual refused to sign.
- Communication barriers prohibited obtaining acknowledgement.
- An emergency prevented us from obtaining acknowledgement.
- Other (Please specify)

  ____
  ____
  ____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Print name of patient: ____

Date of Birth: ______________________________ SSN: ____

I Authorize the Harbor Dental Center to discuss information with:

____

Relation to person listed above:____

What information would you like to disclose to the person listed above:

- All my health information and financial information
- My health information relating to the following treatment or condition
- My health information covering the period from ___________________ to ___________________
- Other ____

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to read additional information provided at the office before you decide whether to sign this consent form. We reserve the right to change our privacy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which contains the changes. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of privacy practice, including any revisions by contacting our office at (410) 228-5445.

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to Harbor Dental Center. Please understand that revocation of this consent will not affect any action we took in reliance to this consent before we received your revocation, and that we may decide to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature of patient: ____Date: ___________________

This notice describes how health information about you may be used and disclosed and how you can gain access to your 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 described in this notice while it is in effect. This notice takes effect 05/15/2023 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 Harbor Dental Center maintains. 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 states 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 billing 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, our 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's 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:

- Prevent or control disease, injury, or disability.
- Report child abuse or neglect
- 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.
- 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 securities. We may disclose to correctional institutions 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.

Judicial and Administrative Proceedings: If you are involved 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 or 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 outlined 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 acted in reliance on the authorization.

Your Health Information Rights: You have the right to look at or get copies of your health information, with limited exceptions. You must make a 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 electronically, you have the right to an electronic copy. We will use the form and format you requested 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 request.

Right to Request a Restriction: You have the right to request additional restrictions 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 Communications: 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 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 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 mail (email)

Questions & Complaints: If you want more information about our privacy practice or have questions or concerns, please contact us.

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 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.

Privacy Official: Megan Covey

Phone Number: (410) 228-5445

Fax Number: (410) 228-5597

Address: 402 Muse Street, Cambridge, MD 21613

Email: Harbordentalcenter@gmail.com