Patient Name_____
Last First MI (Preferred)

Birthdate_____ *Under age 18 □ Yes □ No Parent/Guardian _____
SS#_____-_____-_____ Sex □Male □ Female
Address _____
City _____ State _____ Zip _____
Home Phone_____ Cell Phone _____ Email _____@_____

How did you hear about us? _____
Emergency Contact Name: _____Phone Number: _____Relationship: _____

Method of Payment □ Private or Employer Sponsored Insurance □ Self Pay

DENTAL POLICY IDENTIFICATION

Your relationship to subscriber □ Self □ Spouse □ Child
Subscriber/Policy Holder Name _____ ID # _____
Insurance Company _____ Phone_____
If applicable
Employer _____ Group Name _____ Group #_____

MEDICAL HISTORY

*Please check all that apply

- ○ AIDS/HIV Positive
- ○ Alzheimer's Disease
- ○ Anemia
- ○ Angina
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Blood Disease
- ○ Blood Transfusion
- ○ Breathing Problems
- ○ Cancer/Tumors
- ○ Chemotherapy
- ○ Chest Pains
- ○ Cortisone Medicine
- ○ Diabetes
- ○ Drug/Alcohol Addiction (Within the past 5 years)
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Fainting or Dizzy Spells
- ○ Glaucoma
- ○ Heart Attack
- ○ Heart Pace Maker
- ○ Heart Trouble or Disease
- ○ Hepatitis A/ B/ C
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Hypoglycemia
- ○ Kidney Problems
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Methadone/Suboxone Prog.
- ○ Pain in Jaw or Joints
- ○ Psychiatric Problems
- ○ Radiation Treatment
- ○ Recreational Drug Use
- ○ Rheumatism
- ○ Spina Bifida
- ○ Stomach/Intestinal Disease
- ○ Stroke
- ○ Thyroid Problems
- ○ Tobacco usage
- ○ Tuberculosis
- ○ Venereal Disease/ S.T.D.'s
- ○ None of the above

Allergies:

- ○ Aspirin
- ○ Penicillin
- ○ Codeine
- ○ Latex
- ○ Local Anesthetics
- ○ Metals
- ○ Foods: _____
- ○ Other:_____
- ○ No Known Allergies

Pregnancy

- Are you pregnant: □ yes □ no
- if so, week _____
- Taking oral contraceptives: □ yes □ no
- Nursing: □ yes □ no

Children

- Do you have any of the following habits?
  - ○ Thumb/Finger sucking
  - ○ Clenching or Grinding
  - ○ Tongue Thrust
  - ○ Currently bottle fed -at all
- Is your water fluoridated: □ yes □ no
- Do you still have your wisdom teeth: □ yes □ no

Please list any medications both over the counter and prescription that you are taking: □ Separate list attached □ None

_____

_____

Current Pharmacy _____

Please use the following space to inform us of any medical problems not listed or that you may need to further make us aware of: □ None

_____

_____

DENTAL HISTORY

Do you have any present dental complaints? □ yes □ no

_____

When was your last Full Mouth Xray (or Panorex) taken? _____ Where? _____

**If taken within 5 years, with the same insurance plan, you may be responsible for Xrays taken at Your Smile.*

When was your last dental cleaning? _____ Where? _____

How many times a week do you floss? _____ Really? □ yes □ no How many times a day do you brush? _____

*Do you like your smile? □ yes □ no What would you change? _____

- This form has been minimized for your convenience.
- If you would like to be seen today, we ask that you fill this form out completely and accurately.
- We promise that our current patients will not have to fill them out every time they come in.
- **Please bring these papers, along with your identification and insurance card to the front desk when you are done.**

Your Smile
BEL AIR FAMILY DENTISTRY

OFFICE POLICY (Version 12/01/2022, Copy available upon request.)

General Informed Consent

Examinations and x-rays

I understand that the initial visit may require radiographs to complete the examination, diagnosis, and treatment plan. Radiographs are taken as needed, with a minimum frequency of once per year as part of your periodic oral exam. The type of radiographs may vary but will be consistent with the most current guidelines set forth by the American Dental Association.

Drugs, medication, and sedation

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Changes in treatment

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on teeth, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make these changes as necessary.

Temporomandibular joint dysfunctions (T.M.J.)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joints of the lower (near the ear) after routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, that I will be referred to a specialist for treatment, the cost of which is my responsibility. With any dental treatment, there is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissues. The resulting numbness that could potentially occur is usually temporary, but in rare instances, it could be permanent. I understand that every reasonable effort will be made to ensure that any condition is treated appropriately. No guarantee or assurance has been given to me by anyone that any proposed treatment or surgery will cure or improve any conditions.

Dental Materials

Materials used for treatment may include allergens. I understand that it is my responsibility to inform the staff at Your Smile of ALL allergens or sensitivities. A dental materials fact sheet is available at https://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf. A printed copy is also available at the front desk.

Signature on File

I understand that my signature may be obtained by traditional and/or digital methods. In most cases, any physical forms signed will be scanned and destroyed. The scanned, digital image serves as and becomes part of your permanent dental records.

I hereby authorize Your Smile to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) related to any and all dental benefits due to me and my dependents. I also authorize payment of dental benefits otherwise payable to me, directly to Danielle D. Zhu, DDS, PA. I agree to be held responsible for all charges and services not paid by my insurance company. I understand that if I do not wish to allow Your Smile the consent to use my "signature on file", consent can be revoked at any time. In this instance, a separate consent withdrawal form must be signed and dated. Effective that day, I understand that effective that day, I am responsible for the full office fee for any procedures rendered. As a courtesy, a dental claim form will be provided to me. It is then my responsibility to file my dental insurance claim for reimbursement.

Financial Agreement

I understand that I am responsible for the full fee of any treatment rendered by Your Smile. Acceptable forms of payment include cash, Visa, Master Card, American Express, Discover, CareCredit, Google Pay, Apple Pay, and assigned insurance benefits. I understand that insurance is a contract between the subscriber and the insurance company. In the event there is a shortage due to insurance underpayment or denial, it is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims. After one claim submission, I assume the responsibility for the collection of the claim payments. For any non-covered services, Maryland providers are permitted to charge their office fees regardless of network participation. A reasonable attempt will be made by Your Smile to submit your dental claim on your behalf.

Late Fee/Collections

I understand that an unpaid balance on my account over 30 days is subject to a $10.00 late fee. Payments returned due to non-sufficient funds will be subject to an NSF fee of $45.00. I understand that if my unpaid balance ages over 90 days, it is considered delinquent and may be turned over to a 3rd party collection agency. I understand that I am responsible for all collection fees, attorney fees, and court costs associated and applied to my overdue balance.

Missed/No Show Appointment Policy

Reminder notifications for appointments are a courtesy only. Patients are responsible for remembering their scheduled appointments.

We strive to render excellent dental care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We understand that emergencies can happen and may be out of your control. Therefore, your emergency or situation will be reviewed on a case by case basis. You are still required to contact the office of the event you are unable to keep your appointment. Missed/No Show appointments may result in patient dismissal.

Your Smile reserves the right to assess a fee of $105.00 per patient, per hour for any missed appointments.

A “missed appointment” is defined as follows:

Cancellations: We require that you give our office 48-hour notice in the event that you need to cancel or reschedule your appointment. If you miss or cancel an appointment without contacting our office within the required time, this is considered a missed appointment.

Lateness: If a patient is more than 10 minutes late for a scheduled appointment, this is considered a missed appointment. If a patient is unprepared for their treatment at the scheduled appointment time, the patient will be considered late, therefore it is considered a missed appointment. We strongly suggest that you arrive 10-15 minutes prior to your appointment to ensure that all of your paperwork and payments have been accepted. For your convenience, most paperwork and payments can now be completed online via e-mail or text.

Treatment Changes: Treatment changes require a 48-hour notice, as this may result in the cancellation of your appointment. In order to provide excellent dental care to our patients, we must plan for your visit well before your appointment date. This ensures that we have the appropriate time and materials available for your treatment. If you would like to discuss your treatment options, please feel free to contact our office. Switching appointments with a family member to avoid a missed appointment fee is not permitted.

A “no show appointment” is defined as follows:

No Show: You are not physically present at the start of your scheduled appointment time, and no notice has been given of cancellation or lateness. (All patient communication via text, email, and phone calls are recorded and time-stamped, this includes our receipt and response. If you are unsure that we have received your request, we urge you to try again.)

These fees cannot be billed to your insurance company and will be your direct responsibility. For existing patients, two missed/no show appointments will result in dismissal from our practice. Rescheduled new patients will not be exempt from any scheduling restrictions.

Acknowledgement of Receipt of 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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides 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.

• Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.

• 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 include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health- related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose your protected health information to correctional institutions or law enforcement HIPAA officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

We may release your protected health information for workers' compensation and similar programs.

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 certain rights in regards to your protected health information, which you can exercise by presenting a written request:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, 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 request to receive confidential communications of protected health information from us by alternative means or at alternative locations.• The right to access, inspect and copy your protected health information.• The right to request an amendment to your protected health information.• The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.• 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.

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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA 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, 877-696-6775.

By signing this form below, I am acknowledging that I have read and understand the terms of this office policy.

Patient Name: _____

Parent/Guardian: _____ Relationship: _____

Signature: _____ Date: _____