Welcome~ Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete the following confidential information. In order to properly complete your insurance claims, we must have all information entered. If you have any questions or need assistance, please ask us - we will be happy to help.

Who may we thank for referring you? ______________________________

Date:

PATIENT INFORMATION

Name______________________ Birthdate __________ Age______ Sex: ☐male ☐female

Address______________________ City________ State________ Zip______________

Email______________________ Home Phone____________ Cell Phone____________

Check appropriate box: ☐ Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If child, name of school ____________ Grade________ Hobbies/Sports______________

Occupation______________

Patient or parent/guardian's employer____________________ Work Phone______________

Employer Address______________________ City________ State________ Zip________

Spouse or parent/guardian's employer____________________ Work Phone______________

Emergency Contact ____________________ Phone ______________

RESPONSIBLE PARTY

Person financially responsible for this account ______________________Relationship ____________

Address ______________________Home phone ____________ Cell phone ____________

Email______________________ Birthdate __________ State________ Zip__________

Are you currently a patient in our office? ☐ Yes ☐ No Driver's license # ______________________

Employer ________________ Work phone ________________ SSN ______________

INSURANCE INFORMATION

Name of insured ______________________ Relationship to patient ______________

Birthdate ________________ SSN________________Date employed __________

Name of employer ________________ Work Phone________________

Employer address ________________ City ____________ State ________Zip ________

Insurance ________________ Group #____________Policy ID #______________

Insurance Address________________ City ____________ State ________Zip ________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If **YES,** complete the following:

Name of insured ______________________ Relationship to patient ______________

Birthdate ________________ SSN________________

Insurance ________________ Group #____________Policy ID #______________

Insurance Address________________ City ____________ State ________Zip ________

DENTAL HISTORY

Reason for today's visit ______________________________

Previous Dentist (Name & Phone Number)______________________________

Date of last exam__________ Date of last dental x-rays____________ What was done at that time?______________________________

Drinking fluoridated water?	☐Yes ☐No	Fingernail biting?	☐Yes ☐No	Mouth breathing?	☐Yes ☐No
Bad breath?	☐Yes ☐No	Food collection between teeth?	☐Yes ☐No	Orthodontic treatment?	☐Yes ☐No
Blisters on lips or mouth?	☐Yes ☐No	Sensitivity to cold?	☐Yes ☐No	Periodontal/Gum treatment?	☐Yes ☐No
Burning sensation on tongue?	☐Yes ☐No	Sensitivity to heat?	☐Yes ☐No	Had difficult extractions in the past?	☐Yes ☐No
Chew on one side of mouth?	☐Yes ☐No	Sensitivity to sweets?	☐Yes ☐No	Prolonged bleeding after extractions?	☐Yes ☐No
Cigarette/pipe/cigar smoking?	☐Yes ☐No	Sensitivity when biting?	☐Yes ☐No	Do you wear dentures or partials?	☐Yes ☐No
Gums swollen or tender?	☐Yes ☐No	Sores or growths in your mouth?	☐Yes ☐No	Do you like your smile?	☐Yes ☐No
Clicking or popping jaw?	☐Yes ☐No	Jaw pain or tiredness?	☐Yes ☐No	Ever received oral hygiene instructions?	☐Yes ☐No
Dry mouth?	☐Yes ☐No	Grinding teeth?	☐Yes ☐No	How often do you floss?	
Lip or cheek biting?	☐Yes ☐No	Loose teeth or broken fillings?	☐Yes ☐No	How often do you brush?	

Do you have any dental concerns at this time? Please explain

MEDICAL HISTORY

Physician's Name________________________ Office Phone____________________ Date of last visit__________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen" ☐Yes ☐No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV infection	☐Yes ☐No	Emphysema	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Glaucoma	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Headaches	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Problems	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis Type________	☐Yes ☐No	Skin Rash	☐Yes ☐No
Bleeding abnormally, with Extraction or surgery	☐Yes ☐No	Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Blood Disease	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Cancer	☐Yes ☐No	Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tuberculosis (TB)	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Lower Blood Pressure	☐Yes ☐No	Tumor or growth on head/neck	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Ulcer	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Pacemaker	☐Yes ☐No	Other____________________	☐Yes ☐No

Women:

Are you pregnant? ☐Yes ☐No Due Date__________________ Are you nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

____

Pharmacy Name and Phone____________________________

Allergies

☐Aspirin ☐Local Anesthetic

☐Barbiturates (sleeping pills) ☐Penicillin

☐Codeine ☐Sulfa

☐Iodine ☐Latex

☐Other____________________________

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status or my dependent(s), I will inform the dentist. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent(s) during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependant(s). I authorize the use of my signature on all insurance submissions.

X____ Date__________________

Signature of Patient, Parent, Guardian or Personal Representative

Jonathan L. Harris, D.D.S, P.A.
David H. Steiner, D.D.S., F.A.G.D.
3444 Ellicott Center Drive Suite 103
Ellicott City, MD 21043
410 – 465 – 1900

Office Financial Policy

Thank you for choosing our office for your dental care. We are committed to providing you with the best possible care with courtesy and compassion. In order to achieve these goals, we need your assistance and your understanding of our office policies. Please take the time to read this statement carefully.

Full payment for professional services is due at the time of service unless other arrangements have been made prior to appointment. To accommodate you, we accept cash, check, Visa, MasterCard, and Discover. Outside financing is available upon request and approval.

It is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. As a courtesy, in addition to filing your claims, we will initially ask you only for your estimated co-payment. Patients must understand that our treatment plans are only an estimate and insurance companies are not always predictable and don't always provide us with total information. The financial obligation for dental treatment is between you and our office. Your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract. We will assist you in any way that we can by filing your claims and working to obtain your maximum available benefits. However, it is your obligation to familiarize yourself with your insurance coverage as benefits vary and not all services are covered in all contracts. If your insurance claim is unresolved and goes past 60 days it will be your obligation to pay your account in full.

If your insurance company reimburses you, then a full payment is due at the time services are rendered. In addition, first office visits that are **Emergency visits** – full payment will be expected regardless of insurance.

After dental insurance has paid its portion, a statement is sent to the mailing address on record for the remaining balance. If a check is returned for insufficient funds, there will be a $30 charge fee. Accounts unpaid after 60 days from day of service are subject to a delinquent fee of $25.00. Furthermore the unpaid balance is subject to a 1½ % monthly (18% Annual) finance charge. If we have to submit your unpaid account to a collections process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fees.

Once an appointment has been made, please remember that this time has been specifically reserved for you or your dependent(s). As a courtesy to our patients, we confirm your appointment. The office reserves the right to charge and collect fee ($50) for broken appointments. If you must change your appointment, we ask for at least 48 hours notice.

Thank you for taking the time to read and understand our financial policy. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions.

I hereby do authorize dental treatment and agree to pay all related professional fees for dependent(s) (unless otherwise submitted in writing to our office) and myself. Fees not covered by my dental insurance will promptly pay upon notification from this office. I have read the financial policy. I understand and agree to the terms of this policy.

___________________________________ ___________________________

Signature of Patient or Responsible Party Date

Jonathan L. Harris, DDS, PA
David H. Steiner, DDS, FAGD
3444 Ellicott Center Drive, Suite 103
Ellicott City, MD 21043
410-465-1900

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law 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 April 14, 2003, 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. 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on the website or at the above address.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations 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 other 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 communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by 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, 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 to 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 website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Jonathan L. Harris, DDS, PA
David H. Steiner, DDS, FAGD
3444 Ellicott Center Drive, Suite 103
Ellicott City, MD 21043
410-465-1900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

____
Relationship to Patient

____
Dependent family members also covered by this acknowledgement:

For Office Use Only:

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

- ❑ The patient refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ Emergency situation prevented us from obtaining the acknowledgment
- ❑ Other (Please Specify)

Jonathan L. Harris, DDS, PA
David H. Steiner, DDS, FAGD
3444 Ellicott Center Drive, Suite 103
Ellicott City, MD 21043
410-465-1900
2dentaloffice@verizon.net

Date: _______________

Patient Name to transfer: ___________________________________

D.O.B.: _________________Phone Number: ___________________

Other family members to transfer: ____________________________

Previous Dentist or Practice Name: ___________________________

Address: ____

City/State/Zip: ____

Phone Number: ____

Please forward any of the following information that you have: x-rays, probing depth chart, and pertinent notes that would help us treat this patient. Anything you send us, no matter how old, is greatly appreciated. Thank you!

I hereby give you permission to release any and all of my dental records to Dr. Jonathan Harris.

________________________________ __________________
Patient Signature (parent if a minor) Date