PATIENT INFORMATION		
FIRST NAME:	LAST NAME:	MI:
DATE OF BIRTH:	SEX: ☐ MALE ☐ FEMALE	
ADDRESS: _____ STREET CITY STATE ZIP CODE		
HOME # CELL # EMAIL ADDRESS		
CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED		
PATIENT/GUARDIAN'S EMPLOYER:	WORK PHONE:	
BUSINESS ADDRESS: _____ STREET CITY STATE ZIP CODE		
SPOUSE OR PARENT/GUARDIAN NAME	EMPLOYER	WORK PHONE
IF PATIENT IS A STUDENT, NAME OF SCHOOL	CITY	STATE/PROV.
WHOM MAY WE THANK FOR REFERRING YOU?		
EMERGENCY CONTACT		PHONE

RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT	**RELATIONSHIP TO PATIENT:**
ADDRESS	HOME PHONE
EMAIL	CELL PHONE
DRIVER'S LICENSE	
Birth Date	Financial Institution
Employer	Work Phone
Is This Person Currently a Patient in our office? ☐ YES ☐ NO	

Insurance Information		
NAME OF INSURED	**RELATIONSHIP TO PATIENT:**	
BIRTH DATE	SSN	WORK PHONE
EMPLOYER ADDRESS: _____ STREET CITY STATE ZIP CODE		
Primary Health Insurance Company Name and Address: _____ Insurance Company Name Street City State Zip Code		
ID#:	Group#	Effective Date:
AMOUNT OF DEDUCTIBLE?	HOW MUCH HAVE YOU USED?	MAX ANNUAL BENEFITS

Secondary Health Insurance Information		
NAME OF INSURED	**RELATIONSHIP TO PATIENT:**	
BIRTH DATE	SSN	WORK PHONE
EMPLOYER ADDRESS: _____ STREET CITY STATE ZIP CODE		
Primary Health Insurance Company Name and Address: _____ Insurance Company Name Street City State Zip Code		
ID#:	Group#	Effective Date:
AMOUNT OF DEDUCTIBLE?	HOW MUCH HAVE YOU USED?	MAX ANNUAL BENEFITS

X_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NAME _____ **TODAY'S DATE** _____

HOME ADDRESS _____ **DATE OF BIRTH** _____

_____ **HOME PHONE** _____

EMAIL _____ **CELL PHONE** _____

BUSINESS ADDRESS _____ **BUSINESS PHONE** _____

_____ **SSN/SIN** _____

PATIET MEDICAL HISTORY

PHYSICIAN	PHONE:	DATE OF LAST EXAM

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO	☐	☐
6. DO YOU USE ALCOHOL OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

IF YES, LIST MEDICATION(S) _____

_____

8. ARE YOU ALLERGIC TO OR HAVE HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (IE NOVOCAINE)	☐	☐	BARBITUATES
☐	☐	ANTIBIOTICS	☐	☐	SEDATIVES
☐	☐	ASPIRIN	☐	☐	SULFA DRUGS
☐	☐	IODINE	☐	☐	OTHER

	YES	**NO**
9. DO YOU HAVE PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN WEEKS?	☐	☐
10. WOMEN ONLY: A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL?	☐	☐

11. DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER/ALLERGIES
☐	☐	FAINTING/SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY/ CONVULTIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS/JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES/ULCERS			

_____

_____

PATIET DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS OR FOOD?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
7. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	☐	☐
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OF CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD ISTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

COMMENTS:

I CERTIFY THAT I HAVE READ AND UNDERSTAD THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ASWERED. I UNDERSTAD THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

_____ _____

PATIENT, PARENT OR GUARDIAN SIGANATURE DATE

Laurel Bush Family Dentistry
2111 Laurel Bush Rd. Suite E
Bel Air, MD 21015
443-512-8703

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name:_____ Phone Number: _____

Patient address:_____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

Detailed description of the information to be released: _____

To whom may the information be released [name(s) or class(es) of recipients]: _____

_____

The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): _____

Expiration date or event relating to the individual or purpose for the release: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient _____Print Name_____
Patient Name_____

Laurel Bush Family Dentistry
2111 Laurel Bush Road
Suite E
Bel Air, Maryland 21015
(443) 512-8703

OFFICE GUIDELINES AND FINANCIAL POLICY

Thank you for selecting us as your dental health care provider. We are committed to your treatment being a positive experience. Please understand your financial obligations are considered part of your treatment. The following is a statement of our financial policy.

No Insurance Accounts: Payment I full is expected as services are rendered. We accept cash, checks, MasterCard, Visa, Discover and Dental Fee Plan.

Insurance Accounts: Patients with dental insurance are required to pay their Deductible and Estimated Co-Payment at the time treatment is rendered. Please understand that your estimated portion is what we expect your insurance to pay. However, insurance my not pay the entire portion of the estimation or they may pay more depending upon the circumstances. Any procedure that is performed and not covered by your insurance will become your responsibility. We accept assignment of insurance benefits after confirmation of your coverage. If coverage cannot be confirmed, we do require full payment at the time of service. Any patient seen in this office presenting an insurance card that is not effective for the date of service, will be responsible for the fees incurred at the time of the visit.

The normal procedure for processing insurance claims:

1. Patients should bring necessary dental insurance forms and insurance booklets or cards to verify coverage
2. The insurance form is completed by our office and submitted to the insurance company for payment as a courtesy to the patient.

Billing Fee: Any patient who has not paid the amount due from the first billing statement will be subject to a billing fee of $10 per monthly statement.

Past Due Accounts: Accounts not paid within sixty (60) days from the date of service, will be turned over to our collection agency. All collections and legal fees will be added to your balance.

Returned Checks: A returned check fee of $30.00 will be charged. Immediate remittance in the form of cash, money order, credit card or certified funds is required for a returned check.

Minors: The parent or guardian must accompany a minor for all appointments and must remain in the office while the minor is receiving treatment.

If at any time you have a question about this Financial and Insurance Policy or your account, please do not hesitate to contact a member of our staff for assistance.

I have read the above policy and agree to accept all financial responsibility for:

Patient's Name (Please Print): _____ Date: _____

Signature of Guarantor: _____

Relationship to Patient: _____

Laurel Bush Family Dentistry
2111 Laurel Bush Rd. Suite E
Bel Air, MD 21015
443-512-8703
410-515-1067
info@laurelbushfamilydentistry.com

Effective date of notice: September 16, 2015

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- other uses and disclosures affected by state law.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Laurel Bush Family Dentistry Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Late and Cancellation Policy

Thank you for trusting your dental needs with Laurel Bush Family Dentistry! We understand the occasional need to reschedule or move appointments. As a courtesy, we ask that you provide us with at least 24hr prior notice to your scheduled appointment. However, if the appointment is not confirmed within 24hrs the appointment will be canceled.

Attending your dental appointment on time is important to serving your dental needs. We need the appropriate time to perform dental procedures so that your experience is comfortable and pleasant. As a patient, you are our focus during your scheduled appointment time, and we will respect your appointment time. It is important to our other patients that their appointment times be respected as well. It is for that reason; all late or broken appointments are subject to a non-refundable late fee. **Late appointments (10 minutes or more), cancellations/broken appointments will result in a fee of $50.00 per half hour (30 minutes) and/or denial to reappoint**. This time is required to offer treatment to another patient in need.

We call to confirm appointments as a courtesy to our patients. It is the responsibility of each patient to remember their appointment.

I _____ hereby acknowledge that I will be charged a fee of **$50** for every late or missed appointment. An appointment is considered late if the patient arrives more than 15 minutes after the scheduled visit time. A missed appointment charge also occurs when the patient provides less than a 24hr notice prior to a scheduled appointment. Late and broken appointment fees must be paid in full before any appointment can be rescheduled. Dismissal could occur after the second missed appointment or at the doctor's discretion.

Signed _____ Date _____

List all family members below:

_____

_____

_____

_____

Witnessed _____Date _____

Laurel Bush Family Dentistry
2111 Laurel Bush Rd, Ste E, Bel Air, MD 21015 | 443.512.8703