WELCOME

Thank you for filling out this form completely. Our goal is to help you achieve and maintain excellent dental health. The better we communicate, the better we can care for your needs. If you have any questions, we'll be glad to help! For your convenience you may use your keyboard and mouse to complete this form. Then print the form and fax, mail or bring it with you to your next appointment. Our fax number is 410.442.0484 and our mailing address is 2500 Wallington Way, Suite 204, Marriottsville, MD 21104

Preferred Name:

1. ABOUT YOU

Name: ______________________ Occupation: ______________________

Preferred Name: ______________ Birthdate: ____________ S.S. # ______________

Spouse: ______________________ Occupation: ______________________

Address: ______________________ City: ____________ Zip Code: __________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Home # :______________ Work # : ______________ Cell # : ______________

E-mail address ______________________

2. DENTAL INSURANCE

PRIMARY CARRIER	SECONDARY CARRIER
Ins. Co. ______________	Ins. Co. ______________
Employee: ______________	Employee: ______________
Employer: __________ Group # : ______	Employer: __________ Group # :______
Date of Birth. __________	Date of Birth __________
Employee S. S. # or ID # : __________	Employee S. S. # or ID # : __________

GETTING TO KNOW YOU

Other family members / relatives seen by us: ______________________

How did you hear about us? ☐ Family/Friend ☐ Phone book ☐ Newspaper ☐ Mailer ☐ Other

Whom may we thank for referring you? ______________________

CONSENT FOR TREATMENT

1. I hereby authorize the doctors and staff to take X-rays, study models, photos, and other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctors to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service -unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge of 12% APR will be added to my account.

Patient's Signature ______________________ **Date:** ______________

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________________

____

Date of Last Dental Visit ____________ **Last Dental Cleaning** ____________ **Last Full Mouth X-rays** ____________

What was done at your last dental visit? ______________________________

____

Previous Dentist's Name ______________________________

Address ______________________________ State ________ Zip ________

Telephone ______________________________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? ____________ How often do you floss? ____________

What other dental aids do you use? (electric toothbrush, toothpick, etc.) ____________

Do you have any dental problems now? ❒ YES ❒ NO

If yes, please describe: ______________________________

Are any of your teeth sensitive to:

- Hot or cold? ❒ YES ❒ NO
- Sweets? ❒ YES ❒ NO
- Biting or Chewing? ❒ YES ❒ NO

Have you noticed any mouth odors or bad tastes? ❒ YES ❒ NO

Do you frequently get cold sores, blisters or any other oral lesions? ❒ YES ❒ NO

Do your gums bleed or hurt? ❒ YES ❒ NO

Have your parents experienced gum disease or tooth loss? ❒ YES ❒ NO

Have you noticed any loose teeth or change in your bite? ❒ YES ❒ NO

Does food tend to become caught in between your teeth? ❒ YES ❒ NO

If yes, where? ______________________________

Do you:

- Clench or grind your teeth while awake or asleep? ❒ YES ❒ NO
- Bite your lips or cheeks regularly? ❒ YES ❒ NO
- Hold foreign objects with your teeth? ❒ YES ❒ NO (pencils, pipe, pins, nails, fingernails)
- Mouth breathe while awake or asleep? ❒ YES ❒ NO
- Have tired jaws, especially in the morning? ❒ YES ❒ NO
- Smoke/chew tobacco? ❒ YES ❒ NO

If so, how much? ________ for how long? ________

Snoring? YES NO

Have you ever had:

- Orthodontic treatment? ❒ YES ❒ NO
- Oral surgery? ❒ YES ❒ NO
- Periodontal treatment? ❒ YES ❒ NO
- Your teeth ground or the bite adjusted? ❒ YES ❒ NO
- A bite plate or mouth guard? ❒ YES ❒ NO
- A serious injury to the mouth or head? ❒ YES ❒ NO

If so, please describe, including cause

____

Have you experienced:

- Clicking or popping of the jaw? ❒ YES ❒ NO
- Pain? (joint, ear, side of face) ❒ YES ❒ NO
- Difficulty in opening or closing the mouth? ❒ YES ❒ NO
- Difficulty in chewing on either side of the mouth? ❒ YES ❒ NO
- Headaches, neckaches or shoulder aches? ❒ YES ❒ NO
- Sore muscles (neck, shoulders)? ❒ YES ❒ NO

Are you satisfied with your teeth's appearance? ❒ YES ❒ NO

Would you like to keep all of your teeth all of your life? ❒ YES ❒ NO

Are you interested in whitening your teeth? ❒ YES ❒ NO

Do you feel nervous about having dental treatment? ❒ YES ❒ NO

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? ❒ YES ❒ NO

If yes, please describe

____

Is there anything else about having dental treatment that you would like us to know? If yes, please describe

____

____

____

____

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Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ❐ YES ❐ NO
   If yes, for what? ______
   Physician's Name ______ Phone ______
   Address ______ City ______ State ______ Zip ______
2. Have you taken any medication or drugs during the past two years? ❐ YES ❐ NO
3. Are you taking any medication, drugs or pills now? ❐ YES ❐ NO
   If yes, please list name and dosage below

______

______

______

______

______

______

4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ❐ YES ❐ NO
   If yes, please list: ______
5. Have you been a patient in the hospital during the past five years? ❐ YES ❐ NO
6. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

Condition			Condition			Condition		
Heart (Surgery, Disease, Attack)	❐ YES	❐ NO	Ulcers	❐ YES	❐ NO	Hepatitis A (infectious) B (serum)	❐ YES	❐ NO
Chest Pain	❐ YES	❐ NO	Diabetes	❐ YES	❐ NO	Venereal Disease	❐ YES	❐ NO
Congenital Heart Disease	❐ YES	❐ NO	Thyroid Problems	❐ YES	❐ NO	A.I.D.S.	❐ YES	❐ NO
Heart Murmur	❐ YES	❐ NO	Emphysema	❐ YES	❐ NO	H.I.V. Positive	❐ YES	❐ NO
High Blood Pressure	❐ YES	❐ NO	Chronic Cough	❐ YES	❐ NO	Cold Sores/Fever Blisters	❐ YES	❐ NO
Mitral Valve Prolapse	❐ YES	❐ NO	Tuberculosis	❐ YES	❐ NO	Blood Transfusion	❐ YES	❐ NO
Artificial Heart Valve	❐ YES	❐ NO	Asthma	❐ YES	❐ NO	Hemophilia	❐ YES	❐ NO
Heart Pacemaker	❐ YES	❐ NO	Latex Sensitivity	❐ YES	❐ NO	Sickle Cell Disease	❐ YES	❐ NO
Blood thinners	❐ YES	❐ NO	Allergies or Hives	❐ YES	❐ NO	Bruise Easily	❐ YES	❐ NO
Arthritis/Rheumatism	❐ YES	❐ NO	Sinus Trouble	❐ YES	❐ NO	Liver Disease	❐ YES	❐ NO
Cortisone Medicine	❐ YES	❐ NO	Radiation Therapy	❐ YES	❐ NO	Neurological Disorders	❐ YES	❐ NO
Swollen Ankles	❐ YES	❐ NO	Chemotherapy.	❐ YES	❐ NO	Epilepsy or Seizures	❐ YES	❐ NO
Stroke	❐ YES	❐ NO	Tumors	❐ YES	❐ NO	Fainting or Dizzy Spells	❐ YES	❐ NO
Diet (Special/ Restricted)	❐ YES	❐ NO	Kidney Trouble	❐ YES	❐ NO	Nervous/Anxious	❐ YES	❐ NO
Artificial Joints (hip, knee, etc.)	❐ YES	❐ NO	Psychiatric/Psychological Care	❐ YES	❐ NO	Sleep Apnea	YES	NO

7. Do you have or have you had any disease, condition, or problem not listed? ❐ YES ❐ NO
   If yes, please list: ______
8. Women. Are you: **Pregnant?** ❐ YES ___ Months ❐ NO Nursing? ❐ YES ❐ NO **Taking birth control pills?** ❐ YES ❐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature ______ Date ______

Dentist Signature ______ Date ______

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Roschella & Zinger Dental Group Financial Policy

Roschella & Zinger Dental Group will provide assistance in the completion and submission of your insurance forms. Because we are not a participating provider with any insurance company, this is strictly done as a courtesy.

Your dental insurance is a contract between you and your insurance carrier. We as dentists are not party to that contract. If your insurance company has not paid your account in full within 45 days, the balance is DUE and PAYABLE by you. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We will do our very best to accurately estimate your portion due at time of service. Please keep in mind this is only an estimate as we are unable to guarantee all charges will be paid by your insurance company. Please be aware that some services are not covered based on your employer's contract with the insurance company.

If you are an insured patient your deductible and co-payment are due when services are rendered. If you are uninsured, the full payment for all services rendered is due at the time of service. We accept Cash, Checks, Visa/ Mastercard /Discover/ American Express, and Care Credit.

Please help us to serve you better by keeping your scheduled appointments. Your appointment has been reserved for you at your request. Cancellations must be received at least 24 hours in advance, or a $50 Failed Appointment Fee will be charged.

Authorization:

I understand that there are various costs associated with dental treatment and I authorize the payments directly to Roschella & Zinger DDS, PA of the 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 dependent(s) behalf. I agree that in the event my account is turned over for collection, I will be responsible for the collection fees, interest, court costs and attorney fees.

Signature ____________________________
Date __________________

Roschella and Zinger Dental Group
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 4/14/03, 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.

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.

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, or 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, for the last 6 years, 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Roschella and Zinger Dental Group

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

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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