

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ E-Mail _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____

Do you have dual coverage? Yes _____ No _____ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Dental Information

Do your gums bleed when you brush? Yes _____ No _____

Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____

Do you grind or clench your teeth? Yes _____ No _____

Do you have any fear of dental work? Yes _____ No _____

Date of last dental examination _____ What was done at that time? _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO
 Physician's Name _____ Phone No. _____
 Address _____
4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication or drugs? YES NO
 If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO
 If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure YES NO	Artificial Joints (hip, knee, etc.) YES NO	Hepatitis B (serum) YES NO
Heart Disease or Attack YES NO	Kidney Trouble YES NO	Venereal Disease YES NO
Angina Pectoris YES NO	Ulcers YES NO	A.I.D.S. YES NO
Congenital Heart Disease YES NO	Diabetes YES NO	H.I.V. Positive YES NO
Heart Murmur YES NO	Thyroid Problems YES NO	Cold Sores/Fever Blisters YES NO
High Blood Pressure YES NO	Glaucoma YES NO	Blood Transfusion YES NO
Arteriosclerosis YES NO	Cancer YES NO	Hemophilia YES NO
Mitral Valve Prolapse YES NO	Emphysema YES NO	Anemia YES NO
Artificial Heart Valve YES NO	Chronic Cough YES NO	Sickle Cell Disease YES NO
Heart Pacemaker YES NO	Tuberculosis YES NO	Bruise Easily YES NO
Heart Surgery YES NO	Asthma YES NO	Liver Disease YES NO
Rheumatic Fever YES NO	Hay Fever YES NO	Yellow Jaundice YES NO
Arthritis YES NO	Allergies or Hives YES NO	Epilepsy or Seizures YES NO
Rheumatism YES NO	Sinus Trouble YES NO	Fainting or Dizzy Spells YES NO
Cortisone Medicine YES NO	Radiation Therapy YES NO	Nervousness YES NO
Drug Addiction YES NO	Chemotherapy YES NO	Tumors YES NO
Stroke YES NO	Hepatitis A (infectious) YES NO	Developmentally Disabled YES NO
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO
 If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? Yes, what month? _____ No Are you nursing? Yes No Are you 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 truthfully and the the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Futhermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account.
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

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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._____ for each page, \$_____ 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Steven H. Becker, DDS

Telephone: 410-461-3311 Fax: 410-750-7348

E-mail: _____

Address: 3505 Ellicott Mills Dr.
Ellicott City, MD 21043

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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)

FOR YOUR INFORMATION

INFECTION CONTROL

As a dedicated team, we are concerned about your protection from infectious diseases. Each time you visit our office, a very special trust is placed in our hands. We do not take this trust lightly. That is why we are committed to providing maximum protection to you, our valued patient, against any kind of infectious disease.

All dental team members treating patients wear gloves, masks, and protective eyewear. The team members wash their hands prior to gloving and change gloves between each and every patient.

Between each patient, the treatment rooms are thoroughly wiped with a surface disinfectant. The instrument and dental handpieces are put through a system of ultrasonic scrubbing (the same system a jeweler uses to clean fine jewelry) and then sterilized with a large, pressurized sterilizer called an autoclave. The instruments are packaged in such a fashion that ensures they are never touched before the actual setup in the treatment room, and when the instruments are touched, it is with gloved hands.

Our dental team has been thoroughly trained in infection-control to make your dental visit a safe visit against infectious diseases. We hope by making you more aware of what measures are being taken on your behalf, that your trust and confidence in our team will make your visits a little more comfortable.

FOR YOUR INFORMATION

DENTAL DISEASE & PREVENTION

Dr. Charles Mayo has said that "preventive dentistry can add ten years to human life." For that reason, we do a complete examination and develop a sound treatment plan for each patient we serve. Unless we know where you are, what you want, and plan proper preventive and restorative treatment, all time, money, and efforts can be wasted.

I believe each patient deserves the best I can possibly give them. For that reason, we take the time to help you create a "picture" of what you want. In other words, where do you want to be, dentally, five or even ten years from now? Then, let's make a plan, a master plan which will guide our efforts and yours toward meeting your objective of a healthy mouth.

By helping you plan and then complete the preventive and reparative treatment, you can be assured of getting the highest quality result. Little time and financial resources will be wasted by taking the extra time up front to plan what you want.

Patients either lose their teeth through dental decay of the teeth or through breakdown of the gums and bone that hold the teeth in place. The use of complete dentistry has a goal-oriented approach which removes all factors contributing to the destruction of either the teeth or the supporting tissues.

Other than accidents, the causative factors of accelerated deterioration of the dentition are:

1. Bite related stress (How a person's teeth fit together)
2. Bacterial waste (Plaque which forms every 12 to 24 hours producing acids)

Contributing factors that lower the resistance to the above two factors are:

1. Heredity
2. General Health
3. Nutrition
4. Emotional Stress

A complete dental treatment plan includes:

1. Reduction of stresses to the bite so they are not destructive
2. Restoring the remaining teeth so they can be completely cleaned
3. Educating and motivating the patient to understand and do the maintenance necessary to completely cleanse the dentition.

A prime requirement of good treatment planning is to do the minimum required to achieve optimal dental health. In providing optimal restorations to allow a person to be able to cleanse the mouth gives the benefits of the best comfort, function, and even esthetics to be achieved.