Welcome to Potomac Dentistry

Patient Information

Last Name:_____ **First Name:**_____ **MI:** _____ **Birthdate:**_____

☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other** **SSN:**_____

Address:_____ **Apt. No.**_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone: (____**)**_____ **Work Phone : (**____**)**_____ **Cell Phone: (**___**)**_____

E-mail:_____ **Driver's License#:** _____ **ST:**_____

Employer: _____ ***How did you hear about our office*:**_____

In case of an emergency contact:_____ **Relationship**:_____ **Phone: (**____**)**_____

Accounting Information (If same as above please check here ☐; If not, please fill out below)

Last Name:_____ **First Name:**_____ **MI:** _____ **Birthdate:**_____

SSN:_____ **Relationship**:_____ **Driver's License#:** _____ _____**ST:**_____

Address:_____ **Apt. No.**_____ **City:**_____ **State:**_____ **Zip:**_____

Employer: _____ **Employer Address:** _____

Primary Dental Insurance

Policy Holders Name:_____

Policy Holders SSN/ ID#: _____

Policy Holders Birthdate: _____

Insurance Co.:_____ **Phone#:**_____

Employer: _____ **Group#:**_____

Secondary (Gov't employees only) or Medical Insurance

Policy Holders Name:_____

Policy Holders SSN/ ID#: _____

Policy Holders Birthdate: _____

Insurance Co.:_____ **Phone#:**_____

Employer: _____ **Group#:**_____

Patient Treatment Consent/Assignment and Release

I authorize the Dentist(s) or designated treating staff to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures including administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorized this practice to submit claim forms and receive payment directly from the insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records such as x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested. I agree to be responsible for payment of all services rendered on myself and on my dependents. I agree that I am financially responsible for all rendered services. I have been made aware of all financial policies of the office.

Patient/Parent or Guardian Signature: _____ Date: _____

Welcome to Potomac Dentistry

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all the questions in detail. Remember to include all information even if you do not think it to be important.

Patient's Name:_____ **Date:**_____

Do you have or have you ever been treated for: Circle "Yes" or "No" to indicate whether you have or had any of the following conditions:

Heart Fai1ure	YES	NO
Heart Disease	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Mitral Valve Prolapse	YES	NO
Artificial Joint/valve	YES	NO
High Blood Pressure	YES	NO
Low Blood Pressure	YES	NO
History of Fainting	YES	NO
Rheumatic Fever	YES	NO
Heart Pacemaker	YES	NO
Anemia	YES	NO
Hemophilia	YES	NO
Bleeding Disorders	YES	NO

HIV/AIDS	YES	NO
Hepatitis A (infectious)	YES	NO
Hepatitis B (Serum)	YES	NO
Hepatitis C	YES	NO
Hepatitis-Other	YES	NO
Liver Disease	YES	NO
Drug Addiction	YES	NO
Alcohol Addiction	YES	NO
Sexually Transmitted Disease	YES	NO
Epilepsy or Seizures	YES	NO
Nervousness	YES	NO
Psychiatric Treatment	YES	NO
Phen/Fen Regimen	YES	NO

Blood Transfusion	YES	NO
Stroke	YES	NO
Tuberculosis	YES	NO
Asthma	YES	NO
Sinus Trouble	YES	NO
Allergies or Hives	YES	NO
Diabetes	YES	NO
Thyroid Disease	YES	NO
Radiation/Chemotherapy	YES	NO
Cancer or Leukemia	YES	NO
Arthritis	YES	NO
Rheumatism	YES	NO
Glaucoma	YES	NO

lf you are female, are you:		
Pregnant	YES	NO
Nursing	YES	NO
Taking Birth Contro1	YES	NO
Taking Hormone Medications	YES	NO

WARNING: Antibiotics reduce the effects of birth control pills

OB/GYN:_____ **Phone:** _____

Physician:_____ **Phone:** _____

Please list all current medications (including prescriptions, over-the-counter, herbal supplements) and reason for use:

_____

_____

_____

Are you allergic to: ☐Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Valium ☐ Sulfa ☐ Lidocaine ☐Other _____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

Patient/Parent or Guardian Signature: _____ Date: _____

Welcome to Potomac Dentistry

Dental History

Reason for today's visit:_____ Previous Dentist:_____ Phone #: _____

So that we can best serve you, may we ask why you left your last dental office? _____

Date of last dental visit:_____ Date of last dental exam: _____ Date of last dental x-rays: _____

Date of last Cleaning: _____ How often do you brush? _____ Per day How often do you floss? _____

Do you feel you grind your teeth? _____ Have you ever had *BOTOX*? _____ Are you interested in *BOTOX*? _____

Have you ever had any serious problems with past dental treatment? **Yes or No** ***If yes, explain;***

_____

_____

Do you have or have you ever been treated for: Circle "Yes" or "No"

Bad Breath	YES	NO	Bleeding Gums when Brushing/Flossing	YES	NO
Periodontal Treatment	YES	NO	Clicking or Popping Jaw	YES	NO
Grinding Teeth (Headaches)	YES	NO	Pain, Soreness of Facial Muscles	YES	NO
Food Collecting Between Teeth	YES	NO	Loose Teeth or Broken Filings	YES	NO
Sensitivity to Cold / Hot	YES	NO	Sensitivity to Biting	YES	NO
Sensitivity to Sweets	YES	NO	Smoke/ Tobacco use	YES	NO
Sores or Growths in Your Mouth	YES	NO	Are you happy with your smile?	YES	NO
Do you have dental implants?	YES	NO	Would you like Straighter Teeth?	YES	NO

Medical History Review and Update

Date:_____ ☐Changes ☐ No Changes

Patient's Signature:_____

Dentist/Hygienist Signature:_____

List Changes	New Medication

Medical History Review and Update

Date:_____ ☐Changes ☐ No Changes

Patient's Signature:_____

Dentist/Hygienist Signature:_____

List Changes	New Medication

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health. I understand that I am responsible to inform the office of any changes to my medical and dental health.

Patient/Parent or Guardian Signature: _____ Date: _____

Welcome to Potomac Dentistry

OFFICE AND FINANCIAL POLICY

Thank you for choosing Potomac dentistry and Welcome. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- ***Payment in full:***
  - Payment is due in full at time of service. For patient with insurance estimated patient's portion is due at time of service rendered. For larger treatments a portion (up to 50%) of the amount due may be required when scheduling your appointment. Payment arrangement may be available in certain circumstances.

- ***CareCredit and/or Springstone Financial:***
  - Allow you to pay overtime with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Potomac Dentistry requires ***payment upon time of services rendered.*** Some treatment may require payment upon scheduling.

Our office charges $20 for every office visit, regardless of whether you have insurance or not. We justify this fee as we go above and beyond the industry standards for infection control and safety for our patients. Feel free to ask Dr. Tamami or any of the staff members about how we go above and beyond the industry standards.

In this office, a LAB FEE is charged directly to the patient for any major restorative procedure, requiring an outside lab for fabrication. As an example, the lab fee for generic porcelain fused to base metal crown is $150. You may upgrade to a PFM fused to high noble metal for $250. All ceramic Zirconia crowns cost $300. Full Gold crown runs $400 or more pending the amount of Gold used. **PLEASE BE ADVISED THAT YOUR INSURANCE DOES NOT PAY FOR THE LAB FEES.**

Payments and/or co-payments are due in full by the time services are completely rendered if a payment plan was established.

As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment upon services to be rendered. Please remember that the contract is between you and your insurance company, and your total balance in our office is always your responsibility. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us by your insurance company. However, we have no way to guarantee the actual terms of your insurance policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.

Acceptance of partial payment for services rendered is a courtesy extended to our patients. If, for any reason, your insurance does not pay for the services rendered by Potomac Dentistry, you, the patient, are solely responsible for the balance in full. You are ultimately responsible for knowing and understanding your policy, its benefits, exclusions and limitations.

Welcome to Potomac Dentistry

If you have any questions regarding your insurance, please let us answer them prior to the start of your treatment. Otherwise, the assumption will be made that you are aware of your dental plan coverage and limitations.

Please be advised that all treatment plans are based on estimated fees and coverage provided by your insurance. The information provided by your insurance company does not guarantee payment and the actual insurance benefits may differ from the treatment plan estimate you receive.

We will only pursue Insurance payments for ***60 days*** after that you, the patient, are ultimate responsible for your balance with Potomac Dentistry. We will be happy to assist you in contacting your insurance company. We also realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Delinquent accounts ***(having a balance due for more than 90 days) may be subject to an eighteen percent (18%) APR interest charge; in addition it may be transferred to a collection agency or the Maryland State Clerk of Courts***. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

CANCELLATION POLICY

At least 24 hours advance notice is required for all appointment changes or cancellations. Otherwise, a $90.00 fee is charged for each appointment so affected; and additional $75.00 cancellation fee is charged for appointments with specialists and/or any lengthy treatment requiring a reservation of more than an hour.

Appointment delays do occur occasionally. We realize that your time is valuable and we try to schedule appointments accordingly. But please understand that our delays happen due to dental emergencies that a patient might be experiencing. We ask for your understanding should this occur. As we will also provide you with the same expedited emergency service if needed.

A duplication fee or Transfer fee may be charged when requesting copies of your x-rays and records.

Potomac Dentistry charges $45 for Returned Checks.

We are always willing to work through unusual situations and accommodate our patients in any way possible. We are here to help you get the dentistry you want or need. If you have any questions or concerns regarding our office or financial policies please see one of our treatment coordinators prior to beginning treatment.

Again, thank you for choosing Potomac Dentistry as your dental provider. We appreciate the confidence placed in us as well as the opportunity to serve you.

Humanity - Compassion - Great

Motivates Potomac Dentistry ☺ to devote it's time to your Smiles Perfection!!!©

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Patient/Parent or Guardian Signature: _____ Date: _____

Welcome to Potomac Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THIS 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 on 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 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 of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Patient/Parent or Guardian Signature: _____ Date: _____

Your Authorization: In addition to our use of your healthcare 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, your may revoke it in writing at any time. Your revocation will not affect any use or disclosure 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 Patients 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 (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 to 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 healthcare information for marketing communications without your written authorization.

Required by Law: We may not 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 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 by using the contact information listed at the end of this Notice.)

Welcome to Potomac Dentistry

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 communicate with you about your health information by alternative means or to alternative locations.

Alternative Communication: 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.) Your request must specify the alternative mean of location, and provide satisfactory explanation of how payments will be handled under the alternative means or location your 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.

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: **Farzam Tamami, D.D.S.**

Telephone: **(301) 983-0371**

Fax: **(301) 983-1731**

Address: **10006 Falls Road**

Potomac, MD 20854

Adapted from the American Dental Association HIPAA Privacy Kit for use only by a dentist

January 2003

Welcome to Potomac Dentistry

This form is education only, does not constitute legal advice, and covers only federal, not state, law

(August 14, 2002)

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.

_____

(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)**
