Cosmetic Dental Center
4 Reservoir Circle Suite 100
Baltimore, Maryland 21208
410-486-5678 phone 410-486-5719 fax
www.ddsbaltimore.com

Welcome to our practice! We are truly delighted that you have selected our office to care for your dental needs. We will make every effort to see that your dental visit is as comfortable as possible. We are very sensitive to the feelings of our patients and encourage open communication.

At your first visit, the doctor will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, oral cancer screening, periodontal health evaluation which will include examination of your teeth and soft tissue and study models (if needed). The doctor will listen carefully to your dental concerns and answer any questions that you may have. Please bring your latest full mouth series of x-rays with you to this visit. If you do not have a current full mouth series, one will be taken at this visit. Following this exam, the dentist will discuss their findings, develop a treatment plan that you are comfortable with and be scheduled according to your personal needs.

Please come prepared for your appointment by printing and completing new patient registration forms. If you have dental insurance, be sure to provide all requested information to assist us in the benefit verification. Payment is expected at the time of visit, including your co-pay if you are covered by dental insurance. As a courtesy, we will file claims on your behalf with your dental insurance company. If you would like to finance your dental expenses, we participate with Care Credit and can give you the necessary forms if you are interested in applying.

Unless an emergency comes up, you can expect us to be on time. We ask that you make every effort to keep your scheduled appointments. Missing appointments disrupts sequencing of care and delays completion of your treatment. Please call at least 24 hours in advance if you need to reschedule your appointment.

We appreciate the confidence that you have shown in us and look forward to meeting you! Please call with any questions.

Sincerely,

Dr. Anna M. Finkler
Dr. Larry A. Layton
Dr. Mark Briner

Cosmetic Dental Center

4 Reservoir Circle Suite 100

Baltimore, Maryland 21208

HIPAA Privacy Policy

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 carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by 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 March 23, 2015, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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. We will post a copy of our Notice in our office. The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to another dentist or health care provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure. This may be done electronically or by mail.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend, or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state workers' compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request to us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and health care operations, and certain other activities for the last six 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 fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 4 Reservoir Circle Suite 100 Baltimore, MD 21208.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 4 Reservoir Circle Suite 100, Baltimore,, MD 21208. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 4 Reservoir Circle Suite 100 Baltimore, MD 21208.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer 4 Reservoir Circle Suite 100 Baltimore, MD 21208. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer

4 Reservoir Circle

Suite 100

Baltimore, MD 21208.

410-486-5678

Cosmetic Dental Center of Maryland
4 Reservoir Circle Suite 100
Baltimore, Maryland 21208
410-486-5678

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent:
Name: _____

Address: _____

Telephone: _____

Social Security Number: _____

Patient: Please read the following statements carefully:
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices (HIPPA Privacy policy)
including revisions of our noticeat any time by contacting:
Front office of Cosmetic Dental Center at the address or phone number above

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to front office of Cosmetic Dental Center. Please understand that revocation of this consent will not affect any action we tool in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

SIGNATURE
I have had the opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature of Patient: _____ Date: _____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed consent in patient's chart

Cosmetic Dental Center # MEDICAL HISTORY **4 Reservoir Circle Suite 100 Baltimore, MD 21208**

PATIENT'S NAME_____DATE OF BIRTH _____

Physician's Name _____ Phone ( ) _____ Date of last physical _____
Pharmacy Name _____Pharmacy Phone :_____

In the last five years, have you been: (if yes, please explain)
a. Hospitalized? ❒ Yes ❒ No _____
b. Had a serious illness? ❒ Yes ❒ No _____
c. Had a major operation? ❒ Yes ❒ No _____

Have you ever been told to take antibiotics before dental visits? ❒ Yes ❒ No

Please list all medications (prescription, over the counter or herbal) that you are currently taking?
(Include birth control medications and daily aspirin therapy if applicable)

Have you had an **allergic** or unusual reaction to any of the following?

Dental local anesthetics	❒ Yes ❒No	Penicillin	❒ Yes ❒No		
Ibuprofen (Advil)	❒ Yes ❒No	Latex	❒ Yes ❒No		
Acetaminophen (Tylenol)	❒ Yes ❒No	Metals	❒ Yes ❒No	_____	
Codeine	❒ Yes ❒No	Other Antibiotics	❒ Yes ❒No	_____	

Other Allergies _____

Indicate which of the following you have had, or have at present. Please mark "Yes" or "No" to each item.

Heart ❒ surgery ❒ disease ❒attack	❒ Yes ❒No	Stroke	❒ Yes ❒No	Hepatitis ❒A ❒ B ❒C	❒ Yes ❒No
Chest Pain	❒ Yes ❒No	Diabetes	❒ Yes ❒No	Venereal Disease	❒ Yes ❒No
Congenital Heart Disease	❒ Yes ❒No	Thyroid Problems	❒ Yes ❒No	AIDS/HIV Positive	❒ Yes ❒No
Heart Murmur	❒ Yes ❒No	Glaucoma	❒ Yes ❒No	Cold Sores/Fever Blisters	❒ Yes ❒No
Mitral Valve Prolapse	❒ Yes ❒No	Hay Fever/Allergies	❒ Yes ❒No	Blood Transfusion	❒ Yes ❒No
Irregular Heart Beat	❒ Yes ❒No	Chronic Cough	❒ Yes ❒No	Hemophilia	❒ Yes ❒No
Blood Pressure	❒ High ❒Low	Emphysema	❒ Yes ❒No	Sickle Cell Disease	❒ Yes ❒No
Artificial Heart Valve	❒ Yes ❒No	Asthma	❒ Yes ❒No	Anemia	❒ Yes ❒No
Pacemaker	❒ Yes ❒No	Ulcers	❒ Yes ❒No	Bruise Easily	❒ Yes ❒No
Rheumatic Fever	❒ Yes ❒No	Tuberculosis (TB)	❒ Yes ❒No	Liver Disease/Jaundice	❒ Yes ❒No
Arthritis/Rheumatism	❒ Yes ❒No	Kidney Trouble	❒ Yes ❒No	Neurological Disorders	❒ Yes ❒No
Cortisone Medicine	❒ Yes ❒No	Dialysis	❒ Yes ❒No	Epilepsy or Seizures	❒ Yes ❒No
Artificial Joints (hip, knee etc.)	❒ Yes ❒No	Acid Reflux	❒ Yes ❒No	Nervous/ Anxious	❒ Yes ❒No
Cancer list type _____	❒ Yes ❒No	Tumors	❒ Yes ❒No	Fainting or Dizzy Spells	❒ Yes ❒No
Chemotherapy	❒ Yes ❒No	Sinus Trouble	❒ Yes ❒No	Females only:	
Radiation Therapy	❒ Yes ❒No	Tobacco Use:	❒ (circle) ❒No Chew Smoke	Are you pregnant? How many weeks___	❒ Yes ❒No
Excessive or prolonged bleeding	❒ Yes ❒No	Psychiatric Care	❒ Yes ❒No	Are you nursing?	❒ Yes ❒No
Taking Bisphosphonates	❒ Yes ❒No	Being treated for Osteoporosis	❒ Yes ❒No		

If you answered yes to any item above, please explain;

Any other problem, condition or disease not listed? Please explain;

I understand that 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, or changes to my medical history occur, I will notify this office of such changes.

Patient/Guardian Signature _____ Date _____

Cosmetic Dental Center **DENTAL HISTORY** **4 Reservoir Circle Suite 100 Baltimore, MD 21208**

Welcome! So we may provide you with the best possible care, please complete both sides of this medical/dental history form
All information will be kept confidential

PATIENT'S NAME_____ **DATE OF BIRTH** _____

What is the reason for today's visit? _____
_____

Date of last dental visit _____ **Last dental cleaning** _____ **Last full mouth x-rays** _____

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? Please circle
Mouthwash Water jet device Fluoride supplements Interdental stimulators
Other; please list _____
Do you have any dental problems now? ❒ Yes ❒No
If yes, please describe: _____

Are your teeth sensitive to:

Hot foods or liquids	❒ Yes ❒No	Cold foods or liquids	❒ Yes ❒No
Biting or chewing	❒ Yes ❒No	Sweet/ Sour foods or liquids	❒ Yes ❒No

Have you ever had or noticed:

Mouth odor/bad tastes	❒ Yes ❒No	Loose teeth	❒ Yes ❒No	Tired jaws, especially the morning	❒ Yes ❒No
Bleeding or Aching gums	❒ Yes ❒No	Loose /broken fillings	❒ Yes ❒No	Change in bite	❒ Yes ❒No
Snore or other sleep disorder	❒ Yes ❒No	Tooth Decay	❒ Yes ❒No	Grind teeth while awake or asleep	❒ Yes ❒No
Mouth breathing ❒ awake ❒asleep	❒ Yes ❒No	Dry Mouth	❒ Yes ❒No	Pain (joint, ear or side of face)	❒ Yes ❒No
Food Impaction	❒ Yes ❒No	Difficulty chewing on either side of mouth	❒ Yes ❒No	Head, neck or shoulder aches	❒ Yes ❒No
Burning Tongue	❒ Yes ❒No	Sores , lumps, lesions or swelling of mouth	❒ Yes ❒No	Difficulty opening or closing of mouth	❒ Yes ❒No
Gag Easily	❒ Yes ❒No	Bite lips or cheek fingernails regularly	❒ Yes ❒No	Clicking or Popping of the jaw	❒ Yes ❒No

Have you ever had:

Oral surgery	❒ Yes ❒No	Periodontal treatment	❒ Yes ❒No	Orthodontic treatment	❒ Yes ❒No
Dental Implants	❒ Yes ❒No	Dentures	❒ Yes ❒No	Partials	❒ Yes ❒No
Bite plate / mouth guard	❒ Yes ❒No	Prolonged bleeding following extractions	❒ Yes ❒No	Serious injury to the mouth or head	❒ Yes ❒No

Have you ever been told to take a pre-medication prior to dental treatment? **❒ Yes ❒No**

Is there anything else that you would like us to know regarding your previous dental treatment? ❒ Yes ❒No
If yes, please describe:

Doctor's Notes:

Cosmetic Dental Center
4 Reservoir Circle Suite 100
Baltimore, Maryland 21208
410-486-5678 phone 410-486-5719 fax
baltimoredentists@ddsbaltimore.com

NAME AGE DATE OF BIRTH M/F TODAY'S DATE

ADDRESS CITY STATE ZIP CODE

HOME # CELL # WORK # EMAIL ADDRESS

PREFERRED METHOD OF CONTACT? PLEASE CIRCLE: PHONE TEXT EMAIL

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER

EMPLOYER HOW LONG OCCUPATION

DENTAL INSURANCE SUBSCRIBER NAME, ADDRESS, PHONE & GROUP #

MARITAL STATUS PRIMARY INSURED'S NAME PRIMARY INSURED'S BIRTHDATE

S M D W

REFFERED BY: _____

EMERGENCY CONTACT RELATIONSHIP PHONE NUMBER

GUARANTOR'S SIGNATURE _____(SEAL)

DATE _____

Cosmetic Dental Center
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Baltimore, Maryland 21208
410-486-5678 phone 410-486-5719 fax
baltimoredentists@ddsbaltimore.com

FINANCIAL POLICY

If you have dental insurance, we will be more than happy to submit all insurance forms for you and help you recover the most from your benefits. As a courtesy, we will help determine your estimated co-pay. That estimate is due at the time of service. Any remaining balance after your insurance has paid is your responsibility.

We will do everything we can to help you to afford the treatment that you need and want. Forms of payment accepted include cash, check, major credit cards as well as Care Credit, BeWell and Lending Club Financing.

It is understood that I, or we, will be responsible for all charges for present and future services incurred on this account, regardless of any insurance coverage that I might have. Broken and/ or cancelled appointments without 24 hour notice are subject to a $75 fee. In the event of non payment, I agree to pay all costs of collections, including fees for returned checks, attorney fees of 1/3 of all sums collected, court costs, pre-judgment interest, any failed appointment charges and broken appointment fees as well as interest on the account at 18% per annum.

GUARANTOR'S SIGNATURE _____(SEAL)

DATE _____